Integration of
Human Services
Volume 2

Case Studies

Companion Report
to Volume 1
Survey of Consolidated
Municipal Service
Managers in Ontario

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The report "Integration of Human Services" is published in two volumes:

Volume 1: Survey of Consolidated Municipal Service Managers in Ontario
Volume 2: Case Studies

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Part A: Introduction

1. Context

The Province, through the Social and Community Health Services Implementation Project in the Ministry of Community and Social Services, undertook a survey of Consolidated Municipal Service Managers (CMSMs) in 1999 with the goal of gathering information from the CMSMs on their approaches to the integration of human services. Volume I of this report describes the context in which the survey was conducted, the conceptual framework that was developed to guide the work, the main types of integration reported by the CMSMs and lessons learned about integration.

This volume (II) contains the reports on 10 case study sites. Nine were conducted in CMSMs. One case study, Let's Grow, describes an initiative that is co-ordinated through a coalition led by a public health unit with a catchment area that covers two CMSMs. Exhibit 1, on the next page, shows the sites and the initiatives.

2. Methodology

The case study reports are based on oral and written information provided by the interviewees. We did not attempt to corroborate the information with other sources. Contact names are provided at the end of each report.

Although there is considerable consistency in the topics covered across the reports, they vary to some extent as a result of:

- differences in complexity and scope of the integration initiative,
- the time available to obtain information, and
- the degree to which the focus was on governance and administration, or service delivery.

In cases where the focus was on service delivery, the reports tended to generate more detailed information on processes, benefits to clients and lessons learned.

Selection of Sites and Initiatives for Case Studies

In selecting case study sites, there was no attempt to include sites that had developed "ideal" human service systems. It was believed that detailed descriptions of a range of initiatives and approaches to integration would yield information that could be helpful to other organizations interested in integration. For the most part, the completed questionnaires were used to identify the main types of initiatives – the intent was to have one case study for each main type of integration. Other factors considered were geographic location, size of the CMSM, rural/urban setting, and uniqueness of the initiative.

Exhibit 1. Case Study Sites and Integration Initiatives		
	Sites	**Integration Initiatives**
1	Bruce-Grey-Owen Sound Public Health Unit (Grey and Bruce Counties)	• Services for children: public health unit/MCSS partnership
2	City of Brantford	• Employment: enhanced job opportunities through support to employers (municipality/HRDC)
3	City of Kingston	• Social services and education: municipal/Kingston Literacy partnership
4	City of Toronto	• Homelessness
5	Cochrane DSSAB	• OW case management
6	Dufferin County	• Employment supports in an ERC: municipal/ HRDC/college partnership • Centralized information access – social and community services: municipal/CCAC partnership • Social services and social housing
7	Regional Municipality of Halton	• Healthy Community
8	Regional Municipality of Hamilton-Wentworth	• Public health and social services: management and service delivery
9	Regional Municipality of Ottawa-Carleton	• Employment supports in an ERC: municipal/HRDC partnership
10	York Region	• Services for children • Social services: OW and Child Care

The position was taken that there is no single approach to integration of human services that is 'right'. Rather, the form a service system takes depends factors such as:

- the priorities of the community,
- what is already in place – the players, the services, the gaps,
- geography – remoteness, availability of transportation,
- the human and financial resources that are available, and
- the willingness of partners to share the vision, the risks and the resources.

Two sites were selected to be case studies partly because they would provide information on the opportunities and the challenges that arise when public health and social services are integrated at the level of governance and administration: The Regional Municipality of Hamilton-Wentworth, and the City of Toronto. Another case study describes an initiative in Grey and Bruce Counties; this was selected because it represented integration through an interagency coalition. The remaining case studies focused more heavily on integration at the level of service delivery, although the management component was addressed as well.

Development of the Case Study Reports

Interviews were conducted face-to-face, by telephone, or through a combination of both approaches. Total interview time ranged from two hours to 6 hours (over several sessions). The interview questions were tailored to each site, focusing on one initiative per site with the exception of two sites (Dufferin County and York Region), where additional initiatives were described. Participants included directors or commissioners of social services, general managers, medical officers of health, and program managers.

An iterative process was used to arrive at a final report for each initiative. Following the interviews, a draft report on the case study was written and sent for comment to the persons interviewed. Once feedback was incorporated, the report was sent back for a final review. This process was usually carried out several times.

Caveat

Initiatives that are in early implementation stages, and even those that have been in place for a number of years, continue to evolve. Significant aspects of some initiatives changed from the time interviews were conducted to the time this report was printed, for example, the General Manager in Hamilton-Wentworth has taken another position. The reports on the initiatives were written in the present tense because they were conducted at a point in time. Changes that have taken place since the interviews are not reflected in the text.

Part B: Case Studies

1. Bruce-Grey-Owen Sound Public Health Unit and MCSS

INTEGRATED SERVICE FOR CHILDREN: LET'S GROW

Synopsis

Goal: To promote healthy growth and development of children in the community by increasing early identification of children with special needs and facilitating access to services for families.

The Initiative: Let's Grow is a multidisciplinary coalition of organizations and individuals involved in developing a system of care and prevention for children age 0 to 6 and their families.

Approach: The Let's Grow Committee, a broad-based interagency committee, co-ordinates the management and delivery of three service components: (1) the provision of information about healthy child development to the general public, (2) intensive support for high-risk families, and (3) community development to foster communities that support and nurture families with young children, to support public awareness of Let's Grow, and to strengthen the ability of professional groups to identify high-risk families. Subcommittees and task groups plan and co-ordinate specific activities of the overall initiative.

Services:

- Information provision through print materials and an information line.
- Community development activities include marketing to health practitioners to foster appropriate referrals of high-risk families; a major annual campaign to promote Let's Grow and address specific issues of child health; and annual conferences in which committee members, service providers and the general public are invited to participate.
- Services for high-risk families include assessment, family service planning, case management, service co-ordination (through Care Planning Teams), home visiting, and regular telephone contact.

Partnership and Linkages: The coalition includes community agencies, Grey and Bruce Counties, the Bruce-Grey-Owen Sound Public Health Unit, and MCSS. The initiative has linkages with the local Preschool Speech and Language program, school boards, hospitals, First Nations, MCSS-funded programs, and programs that are funded by the federal government.

Benefits: High-risk families receive services in ways that are sensitive to their needs, resources are used more effectively, staff provide each other with professional support, and staff become more knowledgeable through exposure to other disciplines and organizations.

Lessons Learned: Strategies were identified for managing a broad-based interagency initiative, developing a common organizational culture, and building effective interagency teams. A key lesson learned was that creating effective interdisciplinary, interagency teams takes a great deal of time, and requires the development of common policies and procedures, shared activities, and leadership.

Context

Let's Grow operates within the catchment area of the Bruce-Grey-Owen Sound Public Health Unit. Grey County and Bruce County are two CMSMs located within this catchment area. The Board of Health includes elected officials from the two CMSMs and from Owen Sound as well as two citizen representatives appointed by the province.

The catchment area has six birthing hospitals, two Children's Aid Societies, four infant development programs, two school boards, seven Associations for Community Living, and two First Nations. The area also includes Mennonite communities.

Vision and Mission

"All families with a child from prenatal to age six will have access to and opportunity to participate in the planning of services and resources that support healthy child and family development, in partnership with the broader community."

The initiative's mission is to enhance the co-ordination and planning of services and resources that support healthy child and family development.

Objectives

The goal of Let's Grow is to promote healthy growth and development of children in the community by increasing early identification of children with special needs and facilitating access to services for families.

The specific objectives of the initiative are to:

- identify risks and problems early,
- provide easy access to resources, and
- deliver co-ordinated community services.

The Let's Grow guiding principles were adapted from the Healthy Babies Healthy Children (HBHC) and Making Services Work For People (MSWFP) program principles.

Target Group

Families living in Grey or Bruce Counties who have children up to age six or who are expecting a child.

Approach

The Let's Grow Committee co-ordinates services to children 0 to 6 and their families through interagency collaboration. The committee developed the vision for the initiative and the overall approach and is now primarily operationally focused. Through a variety of subcommittees and task groups, the Committee assesses community needs, sets objectives for the project, develops plans to meet the objectives, and addresses technology needs.

There are three main service delivery components:

(1) the provision of information about healthy child development to the general public,

(2) intensive support for high-risk families, and

(3) community development to support public awareness of Let's Grow, to strengthen the ability of professional groups to identify high-risk families, and to foster communities that are supportive and nurturing of families with young children.

In addition to these core services, additional services that contribute to healthy child development, e.g., reproductive health awareness and recreation, may be introduced. These are co-ordinated through subcommittees and task groups.

All families in the larger community are the focus of healthy growth and development components of Let's Grow. High-risk families are the focus of early identification and intervention services. Service delivery to these families takes place through multidisciplinary teams that are geographically based, an important feature in an area that is primarily rural.

Information for all New Parents

All families with children 0 to 6 have access to information and referral services through a Warm Line and receive regular information packages on healthy child development.

Warm Line

This is a central number that links parents to parenting groups, health services, infant development programs, preschool services, day care, support programs and family resource centres in the area. It is operated through a child care resource centre in Owen Sound between the hours of 8:30 and 4:30. Because there is only one telephone line to the Resource Centre at this time, incoming calls are split. Calls directed to the Warm Line reach a voice mail system.

Print Material

During the HBHC assessment that occurs when children are born, parents are offered the opportunity to receive child development information packages. Close to

100% of families consent. An information package is mailed to parents of children aged 0 to 5. Parents receive the appropriate mail-out following the births of their children, at 6 months, 9 months, 12 months, 18 months and 24 months of age, and every 6 months thereafter until the children reach 5 years of age. Each package contains information pertinent to the age of the child and addresses speech and language development, vision, hearing, safety, nutrition, parenting and community resources. The purpose is to inform parents and to promote early self-identification of health or developmental problems in their children.

Additional information is available or is being gathered through a community mapping exercise that will serve Child Care planning, Early Years and Let's Grow. This typically involves the identification of available services and resources through a detailed survey at the level of a township or neighbourhood. The services and resources are then represented on a map, thereby allowing gaps and overlaps to be seen. At this time, information on services and resources is being used in two ways:

- A roster of parenting courses is mailed to all service providers involved in Let's Grow.
- In conjunction with LEAP, an inventory of parenting resources by geographic area is being developed. This inventory is available through the Warm Line and will eventually be available through all the partner agencies.

Targeted Services for At-Risk Families

High-risk or potentially high-risk families may be self-referred or referred by professionals or agencies in the community, if they have not already been identified through HBHC. Pharmacists, teachers, food bank workers, physicians, midwives, and Public Health Nurses (PHNs) are examples of professionals who might make referrals.

Once identified, the families are assessed and a family service plan is developed. The plan may involve services from any of the participating agencies. Depending on the identified needs, the families are linked to the appropriate community services and resources, e.g., child care, recreation, support groups, home visiting. The level of support varies, depending on the degree to which the family is believed to be at risk. For example, some support groups may be less intense and open to the general public while others may be geared to specific needs of at-risk families. Similarly, home visiting varies in frequency, depending on the needs of the family.

Assessment and Family Service Plan

Screening and in-depth assessment are carried out by workers in the participating agencies using either the PARKIN or LARSON screening tools. The service co-ordinator, other professionals (as appropriate), and the family meet following the assessment. Goals for the family are set at this meeting, based on the results of the assessment and a Family Service Plan is written, in a format developed for the initiative. The plan identifies the goals, the interventions or activities that need to

take place in relation to the goals, and the agencies that are responsible for each activity or action.

Care Planning Teams

Geographically-based Care Planning Teams develop plans of care, referred to as Family Service Plans, for families. The Teams include professionals from the participating agencies. Team membership varies and, depending on the services needed by the families, may include social workers, public health nurses, infant development workers, and other professionals, as appropriate. The families generally participate in the meetings as well.

The Family Service Plan identifies what services are needed and who will deliver them. Each team identifies one member to be the service co-ordinator who ensures that services received by the family are co-ordinated and that the plan is carried out. This is done through periodic meetings of the team working with the family and monitoring by the service co-ordinator. At this time, the majority of service co-ordinators are Children's Aid workers or PHNs working in the Public Health Unit. Some infant development workers are also service co-ordinators. Referrals are made for direct services when indicated, e.g., speech and language.

Home Visiting

Early in the course of the Let's Grow initiative, interventions for high-risk families were addressed through home visiting by professionals, e.g., infant development workers, PHNs or Children's Aid Society workers. Home visiting by volunteers was also available. This type of home visiting tends to be informal, with the volunteers having considerable flexibility in defining their relationships with the families.

With the introduction of HBHC, funding was made available for lay home visiting. The role of the lay home visitors is to provide a parenting model for the high-risk parents, to provide support to the families in dealing with the challenges of everyday parenting, and to advocate for the family. The lay home visitors receive formal training, are expected to follow the care planning approach in the Family Service Plan, and are accountable for the services they provide. Consequently, lay home visitors are usually assigned to higher risk families than volunteers.

The mix of home visitors depends on the needs of the family. The Family Service Plan sets out which types of home visitors will be visiting the family, for what reason, and at what level of intervention. The Care Planning Team, in which lay home visitors may be included, co-ordinates the home visiting for a family.

Families identified as high-risk receive the most intensive level of home visiting support. The intensity of home visits depends on the needs of the family. Home visits may be conducted as often as every two weeks for an indefinite period of time for a family with a need for high levels of support. The intensity of home visiting for a particular family will change as the needs of the family change, for example, there may be a need for a high level of support immediately following the birth but over the longer term a low level of support may be sufficient.

Watchful Waiting

This service is in the process of being implemented. Families with children who are identified as at risk of developmental delay but who are not receiving services directly are offered other services, such as a subscription to the Let's Grow information packages, and are informed about the Warm Line. These parents would receive a telephone call every 3 months after discharge from hospital. The purpose is to maintain a relationship with the family so that, if the need for active intervention arises, the service system will be able to respond.

Community Development

The objectives of community development are to foster communities that support and nurture families with young children, to support public awareness of Let's Grow, and to strengthen the ability of professional groups to identify high-risk families. Subcommittees and task groups plan and co-ordinate specific activities of the overall initiative.

In order to foster appropriate referrals of high-risk families, participating agencies in Let's Grow market the initiative in the community. For example, staff working in the Reproductive Health Program meet with physicians and provide them with resources and information.

To enhance community and professional awareness, the Committee mounts a major campaign every year to promote Let's Grow and address specific issues of child health. The first campaign took place in 1998 and focused on the print materials being developed for parents. The campaign involved politicians and families and used a variety of media, including the press and radio.

The Let's Grow Committee plans an annual Fall conference called Working Together for Family Health. All Committee members, service providers and the general public are invited to attend.

Community needs and service gaps guide the allocation of Let's Grow resources and a community planning process is being instituted.

Management Structure

Let's Grow is an informal (i.e., not by legal agreement), collaborative interagency initiative. Leadership has been provided by the Bruce-Grey-Owen Sound Public Health Unit and the regional office of the Ministry of Community and Social Services, working in partnership.

Grey and Bruce Counties also have a key role and have been integral to the development of Let's Grow from the outset. Their social services and child care co-ordinators have:

- actively partnered with other organizations involved in early intervention,
- participated in advisory committees, and

- been active in the Preschool Speech and Language program.

The Let's Grow Committee

The Let's Grow Committee is co-chaired by representatives of the Public Health Unit and MCSS. Management support and project leadership is provided to the initiative by both organizations. The Committee operates by consensus. Much of the work is carried out through subcommittees, the leads depending on the particular task to be done. A collaborative approach is supported by the shared vision and guiding principles.

The Committee has parent representatives (when available), as well as representatives from MCSS, Ministry of Citizenship, Culture and Recreation, the Federal Government, the Public Health Unit, Preschool Speech and Language, Ontario Works in Bruce and Grey Counties, and community agencies, including managers from the associations for community living and children's aid societies. These representatives include professionals from a variety of disciplines – health, social services, child welfare and child development/education (see Appendix A at the end of this case study for a list of organizations represented).

To accomplish the range and amount of work required in order to implement and sustain this initiative, a strong planning mechanism was needed. The Let's Grow Committee meets every two months. It has a workplan that includes its own tasks as well as workplans for each subcommittee. The workplans are reviewed regularly to monitor progress against objectives and updated accordingly. Chairs of subcommittees and task groups usually are members of the Let's Grow Committee.

Subcommittees/Task Groups

Much of the work of Let's Grow is accomplished through subcommittees that meet each month. Some of the key subcommittees are shown below. In addition to the subcommittees, task groups have been established to deal with funding, promotion, the Warm Line, conference planning, and ad hoc or time limited issues.

HBHC Implementation –

- facilitated implementation of components of HBHC. For example, the subcommittee provided training to HBHC home visiting staff (as well as to other home visitors) on risk identification, service planning, case management, substance abuse and mental health.
- developed a referral form for children aged 0 to 2 who are receiving services from an agency in Grey or Bruce Counties and who would benefit from referral to the HBHC initiative. The form was distributed to agencies that work with high and at-risk clients.
- is developing a standards manual which will contain the Let's Grow vision, principles, a description of the partnership, roles and responsibilities, policies and procedures (safety practices, referral, developing a family service plan in a multi-agency environment, accessing resources in the community, etc.).

Recreation – is developing a model for incorporating recreation services into the service plans for high-risk families. National Child Benefit reinvestment funds are being used to support this activity.

Reproductive Health – promotes optimal reproductive health in Grey and Bruce Counties. Reproductive health is seen as fundamental to the health of children. This subcommittee develops and initiates projects that will have a positive impact on specific reproductive health issues, such as folic acid awareness and participation in smoking cessation workshops.

Community Development – promotes and supports the development of community partnerships and participation in Let's Grow. It is exploring ways to promote the use of recreation services by the general public and is participating in the community mapping exercise. A subgroup is developing contacts within the Amish and Mennonite communities to increase their awareness of the Let's Grow initiative.

Writing – writes, edits, and publishes the "Let's Grow" mail-outs.

Evaluation – evaluates the effectiveness of the Let's Grow mail out packages, maintains awareness of other relevant evaluation initiatives and incorporates useful components, prepares an annual report that includes evaluation outcomes for each subcommittee.

Linkages

Public Health Unit

The mandated programs of the Bruce-Grey-Owen Sound Public Health Unit – child health and reproductive health – are planned and integrated through the Let's Grow system of care. A co-chair of the Let's Grow Committee is the Assistant Director of Population Health in the Unit.

Hospitals

RNs working in the birthing units in County hospitals receive orientation to Let's Grow from PHNs. This enables the RNs to promote Let's Grow to new parents. Following a birth in the hospital, the nurses ask new parents to sign a consent form allowing the birth to be listed in the Let's Grow database. This database is used to generate lists for the age-specific mail-outs that all parents on the system receive.

Healthy Babies Healthy Children

The relationship between the RNs and PHNs, developed at the initial stages of Let's Grow, served as a foundation upon which the delivery of HBHC was built. The PHNs provide training to the hospital nurses who then screen the new parents. The screening results are sent to the PHNs who then come to the hospitals to meet with

the high-risk families. The PHNs and the RNs also jointly conduct postpartum support programs.

Let's Grow lay home visiting services are provided through HBHC and the co-ordinator for HBHC is a member of the Let's Grow Committee. Many HBHC PHNs participate in Let's Grow subcommittees or task groups.

The Public Health Unit and MCSS have shared responsibility for establishing HBHC and have been equal partners in developing the system of care and prevention. They work together closely to address and resolve any issues that arise.

Preschool Speech and Language

Under the Preschool Speech and Language Initiative, speech and language pathologists have a responsibility to develop community awareness of healthy development of communication skills in children. In keeping with this objective, they contribute to the development of the information packages and help to fund the packages. The co-ordinator of Preschool Speech and Language is a member of the Let's Grow Committee and the chair of the Let's Grow Committee is a member of the Preschool Speech and Language Committee. To facilitate these cross-overs, the meetings of each group are generally held on the same day.

Preschool Speech and Language and Let's Grow have mounted joint initiatives, for example, they set up screening centres which included staff from all participating agencies and a speech and language pathologist. A speech and language pathologist also participates in cross-training for lay home visitors and others, providing training and education on speech and language development in the early years.

School Boards

Members of the education community provide input on school readiness, which was also a major topic of the 1999 Working Together for Family Health conference (described under Community Development, above). Educators sit on several subcommittees and are members of the team preparing the print materials that are sent to parents.

Early Years

South East Grey Community Outreach has been selected as a pilot Early Years site. The pilot will include both Bruce and Grey Counties. A relationship between the pilot and Let's Grow will need to be developed, likely through shared committee membership. Much that is being done for Let's Grow will be of use to the Early Years pilot, e.g., the community resource mapping.

Other linkages

The two Let's Grow co-chairs are members of the Bruce-Grey Planning and Co-ordinating Committee, a non-mandated interagency group, funded by the Trillium

Foundation. This committee advocates for children 0 to 18 years of age and their families, develops policy and promotes local collaboration. There are also links to federal programs, such as the CAP-C, Canadian Prenatal Nutrition Projects, and Brighter Futures.

Benefits

Benefits for Families

FAMILIES ARE PROVIDED WITH SERVICES IN A WAY THAT IS SENSITIVE TO THEIR NEEDS

By having different professionals work together to address the needs of individual families, the staff of the various organizations are learning to work as teams rather than as representatives of specific agencies. It is expected that a team approach to service delivery will lead to increased co-ordination and more effective intervention strategies for families. For example, in the absence of a co-ordinated approach, individual agencies are likely to direct the highest level of intervention toward high-risk families, without assessing the capacity of these families to handle the total set of interventions delivered by all the agencies. The family service planning approach will lead to more thoughtful and comprehensive strategies that are sensitive to the capacity of families to tolerate and benefit from interventions. As well, through ongoing exposure to other professionals and organizational cultures, staff will become more "generic" and able to view families more holistically.

THE LET'S GROW APPROACH HELPS FAMILIES STRENGTHEN THEIR CAPACITY TO BE EFFECTIVE

The mail-outs provide families with information about healthy child development. The care planning process involves high-risk families to a multi- disciplinary approach to family intervention and provides them with an opportunity to have input into their own services. As a result, families develop a better understanding of their needs; know where they can get assistance; are able to engage in more independent decision-making; and are more amenable to intervention.

Benefits for the Organizations

MORE EFFECTIVE USE OF RESOURCES

Teams consisting of the appropriate mix of staff can be pulled together for short periods of time. Materials developed by one group can be used by others. For example, training materials have been shared among the agencies.

Benefits for Staff

Staff gain expertise – Staff learn from each other in the course of team assessment and service planning.

Mutual support – Staff dealing with complex family problems experience support from their colleagues.

Accountability

Reporting to Community Partners

Workers track their time separately and report within their own organizational structure. However, the Evaluation Subcommittee of the Let's Grow Committee recently conducted a study in which the amount of time contributed to committees by each of the participating agencies was tracked. The data will be used to determine the cost of meeting time, using a formula that has been developed.

The Let's Grow Committee and each subcommittee and task group prepares an annual report which is provided to each participating agency and to the two lead partners (MCSS and the Public Health Unit). The agencies are asked to provide the report to their Boards.

The Let's Grow Committee co-chairs provide an additional linkage to the partner organizations. Upon request, they make presentations on Let's Grow to the boards of partner agencies and/or their executive directors.

Evaluation

An evaluation of the Warm Line showed that it is under-utilized. This is attributed to the fact that callers cannot directly access a person but must leave a message.

The print information was evaluated on two occasions. The first was a telephone survey that was conducted early during implementation of the initiative. More recently, a written questionnaire was sent to parents of the 18 month group of children. The telephone survey yielded positive results. The parents had read the pamphlets and retained information they contained. Evidence for this was that respondents knew where the pamphlets could be located in their homes, could answer questions about the contents of the pamphlets, and could cite specific information in the pamphlets.

The Committee is interested in assessing the value of staff participation in Let's Grow. The intent is to examine the relationship between time contributed to the development and maintenance of the Let's Grow partnership and family outcomes. Anticipated results are that families receive services from a larger variety of agencies and that interagency collaboration contributes to the achievement of positive outcomes for families.

Technology

Let's Grow Database

A database to support the print material mail-outs was developed in 1996/97 to capture the information on all children born in the area. This information is used to develop lists identifying families that need to be sent information packages, when the information should be sent out, and the information package that is required.

Program/Service Planning

Integrated Services for Children Information System (ISCIS) is being developed for the HBHC initiative. It will capture information on all newborns in the area and will be used to track high-risk families.

Resource Database

This database supports the information and referral function. It was developed by the local Community Care Access Centre (CCAC) and is available on diskette to staff on the Warm Line and to all participating agencies. Several organizations, including the Public Health Unit, update their respective diskettes with resource information and send them to the CCAC to merge. All Let's Grow agencies have access to the database.

Lessons Learned

Building and managing an interagency initiative is much more work than managing a single agency and creates a host of challenges. For example, participating organizations may have different standards of practice, hiring practices, skill sets within the staff, organizational cultures, and compensation plans, e.g.:

- Staff with comparable levels of responsibility may earn different salaries.
- Practices regarding cancellation of appointments and coverage during holidays may vary.
- Qualifications and education requirements may vary across organizations for staff performing the same activities.
- Words mean different things in different organizations.

These differences may be barriers to the development of positive working relationships among the partners and to the delivery of integrated services. Differences become very apparent when organizations work together. Having multiple agencies (e.g., 7 associations for community living that operate four infant development programs) carrying out comparable activities compounds the challenge.

Some of the challenges faced by the Let's Grow initiative, and strategies that have been found to be effective, are described below.

Managing at a System Level

To manage a human service system, one must identify the end goal and then develop strategies to achieve the goal. These strategies will change as one proceeds. More effective ways of achieving the goal are identified through the feedback that is received and the lessons that are learned.

Ongoing support for the operational units of the system (e.g., the teams, subcommittees, and task groups) becomes a core function of the system manager.

As the system develops, the system itself becomes the focus, as opposed to the component parts. The shape of the system changes over time – some components are eliminated and new ones are added.

A collaborative approach requires that partners put aside their own professional interests for 'the greater good'. Not only staff, but the leaders and managers need to undergo personal change – they need to deal with their own 'turf' issues (e.g., implications of the approach for staff within their organizations) and attitudes to their partners in the initiative.

Developing a Common Culture

In developing an interagency approach, it is important to foster a common culture. A key activity is developing a shared vision. The Let's Grow vision statement was developed by the Let's Grow Committee without difficulty.

When decisions need to be made in a context of competing perspectives and priorities, bringing the attention of team members to the agreed upon vision can be helpful in reducing conflict. However, this is difficult in a demanding environment and in the context of short-term issues. The commitment of the leaders of the Let's Grow initiative to the vision has been critical in keeping the vision alive and relevant.

Other strategies for developing a common culture include:

- conducting cross-training (i.e., training delivered to staff in the partner agencies in combined groups) that is planned and delivered jointly by the partners,
- jointly developing a shared vision and common values, principles, standards of practice, referral protocols, etc.,
- jointly developing products for common usage, such as a policy manual and resource database, and
- developing effective processes at a management level for addressing issues arising from joint activities.

Finally, managers must be seen to support the approach by working collaboratively.

Building Effective Interagency Teams

It takes a long time and much effort to create effective teams that combine staff from different organizations and cross professional boundaries:

- In bringing together staff, it is helpful to place discussions within the context of the shared objectives – e.g., best interests of the family, best use of resources.
- Outstanding work should be recognized. For example, each year, a Let's Grow subcommittee or task group is given a lunch in recognition of their work. This announcement is made at the annual Let's Grow conference.
- At times, it may be necessary for particular individuals to champion specific aspects of the initiative. When there appear to be irreconcilable differences, bringing in a neutral person may be helpful – someone who is perceived to be objective and who can assist the group to bring forward new ideas. In the Let's Grow initiative, bringing the MCSS representative into the Committee helped the group to move forward. Similarly, bringing new team members into the Let's Grow Committee has helped maintain momentum.
- Joint training initiatives and shared management of training activities foster teamwork.

AT THE SERVICE DELIVERY LEVEL

Multi-disciplinary: Workers from different agencies work together more effectively when there is a common focus on the needs of individual high-risk families. The expectation is that bringing together the various types of service providers will help team members to become more inclusive in their thinking about potential resources for families. For example, it may be that recreation services would significantly benefit a family or a family might benefit from contact with resource centre staff. By including not only Children's Aid Society workers and PHNs but other service providers such as recreation workers and child care workers, teams are more likely to develop comprehensive and co-ordinated interventions.

Geographically-based: The team members that know the local communities are able to use natural and other community supports effectively.

AT THE ADMINISTRATIVE LEVEL

Committees and task groups are most effective when:

- there is consistent membership, and
- clear expectations that include achievable and quantifiable outcomes are set through work plans.

Developing New Ways of Doing Business

Creating new ways of doing business is exciting but it can also be stressful and time consuming. It is easier to do things "the old way". A culture of innovation and willingness to stretch oneself needs to be developed. This requires that managers support their staff when staff try out new roles or approaches.

Managing Home Visiting

Home visiting is a good service for families and a cost-effective way of delivering service. However, it takes a great deal of time to manage and train the home visitor.

Effort needs to be put into guarding against misuse of the home visitors. This may occur if home visitors are asked to be responsible for tasks or interventions that they are not qualified to perform.

Involving both lay and volunteer home visitors, groups that were brought into the system of care at different times, is challenging. Different expectations are held of each group and one group is compensated while the other is not. These differences are potential sources of tension.

Providing Training in Case Management

At this time, most of the case management is carried out by Children's Aid Society workers and PHNs. A longer-term objective is to have workers from other participating agencies be service co-ordinators. This will result in the work being more evenly distributed and would help to improve co-ordination across agencies. The experience thus far has been that the planning and carrying out of training events presents significant resource challenges that detract from direct services.

Sharing Responsibility for Families

In some instances, workers may feel overly responsible for a family because of the nature of the presenting problem and may be reluctant to include other types of interventions or organizations. Managers need to support collaborative service planning in order to address this.

Community Development through In-person Contact

Providing support to high-risk families depends, in part, on the ability of professionals in the community to appropriately identify these families. Professionals in the community who could be sources of referrals of high-risk families have a better understanding of what to look for and the resources available if the information is provided in-person rather than through print materials.

Development of the Initiative

The catalyst for development of the Let's Grow initiative was the termination of the Public Health Unit's preschool screening program in 1995. With the end of this program, developmental delays were not identified, in many instances, until a child entered the school system. To deal with this circumstance, planning for the Healthy Growth and Development Project began in 1995. The intent of the Healthy Grow and Development Project was to identify children with special needs during the

preschool period and to ensure that these children and their families received appropriate interventions.

When HBHC was introduced in 1997, it was evident that it complemented the Healthy Growth and Development project so the two were combined under one umbrella to form Let's Grow. The Let's Grow Committee's mandate is to develop a system of care for all children aged 0 to 6, and their families. Membership of the Committee includes representatives from each agency providing services to children in the PHU's catchment area.

The Warm Line was an enhancement of an information line developed by a local child care resource centre. This centre had a 1-800 line that was answered by a worker three days per week. The worker provided parents with information about child care options in the area. Under the Let's Grow initiative, the scope of the information provided was expanded to include information on services provided by all human service agencies in the area. To do this, a voice mail system was implemented – callers could leave a message that would be returned. The idea was that residents could call one number to get information about a variety of services rather than call agencies individually. As described above, under Evaluation, this approach has been found to be unsatisfactory and alternatives are currently being explored.

Future Plans

With the devolution of Child Care to CMSMs, the plan is to extend the hours during which the Warm Line is available and to add resources so that callers are connected directly to a service provider.

The initiative is heading towards a wrap-around approach. Efforts will be made to ensure that families receive the range of services that they require.

Community development activities will continue to focus on developing the geographically-based, multi-disciplinary service teams.

The Let's Grow Committee will be addressing the needs of the Mennonite community in future service planning activities.

Evaluation will be on-going.

Service planning will become more focused on building family capacity – how to help families become stronger and better able to meet their own needs.

For additional information, contact
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Appendix A

Agencies/Organizations Represented on Let's Grow Committee

Bluewater District School Board
Bruce County Children's Aid Society
Bruce County Family Resource Network
Bruce County Ontario Works
Bruce Grey Children's Services
Bruce-Grey-Owen Sound Public Health Unit
CAPC – Brighter Futures
Cape Croker Medical Centre
Children's Aid Society of Owen Sound and County of Grey
Choices
Community Care Access Centre
Community Living Kincardine and District
Community Living Owen Sound and District
Grey Bruce Health Services
Grey County Social Services
Grey-Bruce-Huron-Perth District Health Council
Grey-Hanover Resource Centre
Medical Services Saugeen First Nations
Ministry of Citizenship, Culture and Recreation
Ministry of Community and Social Services
Native Child Welfare
Parents from the community
Southeast Grey Community Outreach
Southeast Grey Support Services
Victoria Order of Nurses
Walkerton and District Community Support Services

2. City of Brantford

SUPPORT TO EMPLOYMENT THROUGH OUTREACH TO EMPLOYERS

A Partnership between City of Brantford and Human Resources Development Canada

Synopsis

Goal – The goal of Brant County Employment Services (BCES) is to increase the number of people entering the job market in Brant County by expanding the listings of employment opportunities and providing supports to local employers.

Approach – The City of Brantford and Human Resources Development Canada (HRDC) entered into a partnership in order to achieve this goal. Together, they established a Marketing Team to seek out employment opportunities in Brant County. The team markets BCES to employers in a variety of ways, from cold calling employers to attending Chamber of Commerce events. A comprehensive marketing plan is developed each year.

Clients – Job vacancies identified by the team are made available to anyone in the community through the HRDC Job Bank, radio announcements, newspaper ads, etc. Ontario Works participants are not given preferential treatment. However, new job vacancies are "advertised" in the Ontario Works Resource Centre and brought to the attention of participants in groups/workshops.

Services to Employers – The Marketing Team identifies employer needs and determines how best to meet those needs, facilitating access to any other programs or services in the community that would be helpful (e.g., wage subsidies, assessment). A variety of direct services are provided to employers by the Marketing Team with the assistance of HRDC and Ontario Works: screening and testing of job seekers, running job fairs and providing interview space and assistance are services provided on a regular basis.

Benefits – Employers receive high quality assistance with recruitment. Job seekers have access to an inclusive job bank. Indirectly, community service providers receive free marketing of their services by the Marketing Team.

Vision

To become the primary supplier of Human Resource services to the Brant County business community.

Principles

Three key principles underlie the service delivery model:

One-stop shopping for employers: Employers in the community should have a single contact point to access the Brant County job seeker pool, and information and services to support recruitment.

The best person for the job: All suitable job candidates are referred for positions. There is no preferential treatment for clients of either partner, that is, Ontario Works or Employment Insurance.

Excellent customer service: The Marketing Team and the Order Service Team ensure appropriate referrals and successful job placement in a timely manner. Provision of a high standard of customer service means that a critical mass of County employers keep coming back to BCES to help meet their human resources needs.

Clients

The primary clients of the initiative are employers in Brant County. The secondary clients are all job searchers in Brant County, including Ontario Works participants.

The Service Delivery Model

There are three main components in the service delivery model: job posting, outreach to employers, and support to employers. These activities are carried out by:

- a Marketing Team that reaches out to employers in the business community and provides supports to them, and
- an Order Service Team which receives job orders (vacancies) and posts them on the HRDC Job Bank; the Job Bank can be accessed by any job seekers in the community, as well as via the internet.

Job Posting

Job posting is a critical component of the service delivery model. Job postings are obtained in two main ways: marketers visit employers who advise them of vacancies,

or, employers call the BCES Marketing Team with postings. As well, any employers, whether or not they are involved with the Marketing Team, can call into the Order Service desk at HRDC to post their jobs. In either case, the vacancy is immediately posted on the electronic Job Bank by the Order Service Team at HRDC.

Job seekers are able to access the Job Bank directly. Many agencies, including the OW Resource Centre, post hard copies of these orders daily.

When a job order needs to be filled immediately, the marketers go into a high action mode to meet the employer's demands, e.g., announce the vacancy in the Employment Resource Centre and at group meetings in the Centre; inform case managers, the intake department, other community agencies, the community college, etc.

Outreach to the Business Community

The Marketing Team reaches out to the business community through a range of public relations and promotional activities:

Networking – the team members attend various business and personnel meetings and functions such as the Personnel Association, Service Clubs, Economic Development Board, and Chamber of Commerce.

Promotion – the team distributes a newsletter and other promotional materials to employers in the community; advertising regarding the services available to employers is placed in the Chamber of Commerce magazine.

Supports for Employers

Employers are able to access a range of supports and services through the Marketing Team. These include:

Information

The Marketing Team has extensive knowledge of the current training and employment subsidy programs available to employers, from all levels of government and from community agencies. As well, employers are provided with up-to-date labour market information, for example, how much a certain position pays in Brantford, availability of skilled workers in the area.

Assistance in accessing training and employment programs

The Marketing Team is able to identify the range of employers' needs. This is accomplished by conducting a thorough work environment analysis of the company. The marketer then assists the employer to access subsidy and training programs.

ASSISTANCE WITH RECRUITMENT

From their workplace analysis, the team selects suitable job candidates from the resumés received in response to the posting. A package of resumés is sent to the company by the Marketing Team. The company carries out the final selection and conducts the hiring process according to its own specifications.

Finding suitable referrals for posted positions is a critical step. Three Customer Service Representatives work with the Marketing Team to ensure that employers' needs are reflected in the resumés which are presented to them.

When required by the employer, candidates for a job can be pre-tested at the Employment Resource Centre. The Marketing Team follows-up with the employer to ensure that the placement is a success, troubleshooting if necessary, and conducts surveys of employers in order to assess customer satisfaction. As well, the Marketing Team helps to run job fairs and provides interview space and assistance.

OUTPLACEMENT SUPPORT

BCES has been successful in obtaining bids for outplacement contracts (for a fee) from area employers who are downsizing. BCES' extensive knowledge of the business community and proven success in job placement have been deciding factors in establishing BCES as an outplacement service.

Staffing and Training

Order Service Staff

The job order-taking service for employers is staffed by 3 Ontario Works employees who have been trained by BCES to provide a high standard of customer service. The Order Service staff are located at the HRDC office and have been trained on the federal NESS (National Employment Service System) software, by HRDC. Their responsibilities include:

- taking job-order calls from the community and from the Marketing Team,
- entering the job orders into the NESS database,
- recording placements and following-up on both provincial and federal software programs:
  - Information is entered into the OWT (Ontario Works Technology) system to ensure that case managers are aware of job placements, non-compliance, etc. This technology also records the statistics for funding through Employment Placement.
  - The federal system records increases in job placement activity, labour market information (such as the types of employment in demand and wages being offered) and is used by EI case managers for clients in receipt of these benefits.

- announcing job openings on local radio stations.

Marketing Staff

Four Marketing staff are located in the City of Brantford OW office – 3 are City of Brantford employees and 1 is a seconded HRDC employee. The Marketing Team is also trained on NESS, which they use to check job orders on the system.

The marketers are required to be able to speak knowledgeably to the business sector about all employment programs currently offered in the County. To keep abreast of new programs, subsidies, training courses, etc., the Marketers undergo continuous updating and training, including monthly meetings with community agencies.

Linkage with Ontario Works

The Marketing Team is co-located with the Employment Support team, Community Placement staff, and the Employment Resource Centre in the Ontario Works Office. There is a separate entrance to BCES which is designed to offer a "business environment" to clients.

Since the success of this initiative depends on the suitability of job-ready candidates who are referred to employers, the OW Employment Support team works closely with BCES to ensure that OW participants have all of the necessary "soft skills" required for employment, such as interview preparation, job maintenance and teamwork, as well as well-written resumés.

Three OW Customer Service Representatives assist the Marketing Team. They are required to have in-depth knowledge of the employers and the businesses to which they are referring resumés so that only the most appropriate applicants' resumés are forwarded. Their training involves visits to employers with the Marketer for the workplace analysis as well as networking at business functions. Customer Service Representatives usually have an employment counselling background and are skilled at assessing the suitability of clients for jobs. It is also their responsibility to ensure that the resumés of OW participants who meet job posting requirements are sent to the employer.

Information and Technology

Recording employer and client activity, non-compliance issues, and orders filled, is extremely important to both organizations for the purpose of case management and outcome based funding.

As jobs are filled, this information is entered on NESS by Order Service staff. The Order Service staff also search on OWT for the name of the successful job seeker. If there is a match on OWT, the caseworker for the OW participant is automatically notified through the system, and the City is credited appropriately through

Employment Placement. The NESS system is also available to the Marketing Team on site at the Ontario Works office.

The Partnership

Each partner contributes 50% of the costs of the Marketing Team, advertising and administration. A Memorandum of Agreement covers human resources and financial issues. The agreement between the two organizations sets out three objectives:

- a 10% increase in the number of listed job vacancies per year,
- increased use of targeted programs as a result of marketing, and
- increased number of referrals to other community programs that serve employees.

The Marketing Team is directly supervised by the Manager of Employment Services (OW). Order Service staff are supervised by HRDC. Each organization respects the other's collective agreements and employees also formally report within their own organization. Each organization provides informal feedback to the other regarding the seconded staff and attainment of the initiative's goals.

Support at the Political Level

When an impasse between the two organizations was reached due to divergent philosophies, each organization involved their respective politicians. A compromise was negotiated and agreement was achieved because a shared belief in the potential service benefits of this initiative was endorsed at the political level.

Governance and Accountability

The Social Services Committee of the City of Brantford (the CMSM) has endorsed and encouraged this initiative from the outset.

All the organizations in the community that provide employment services are considered to be stakeholders. Communication is maintained with these organizations through a newsletter and by having staff provide updates at regular meetings with them.

Service quality is monitored through a questionnaire given to employers who use the services. The questionnaire probes professionalism of staff, timeliness of services, whether or not needs were met, other services required, etc. Results are compiled in a summary report which is used for accountability and marketing purposes.

The City provides written statistics to HRDC on a monthly basis: numbers of employer contacts, packages mailed out, job orders brought in, etc.

Benefits of an Integrated Approach

Benefits to Clients

More jobs are available to OW participants and EI clients.

Benefits to Employers

One-stop shopping

Employers are able to post their vacancies with the Marketing Team and be assured that both partners (HRDC and the City of Brantford) as well as the community partners will be notified. This saves them the time and the expense of advertising.

Providing employers with one point of contact for finding out about business subsidy and training programs and assistance with applications ensures that they can make an informed decision.

Pre-screening

The pre-screening of applicants saves valuable employer time. It is common for employers to receive hundreds of applications from a single ad. Brant County Employment Services screens these applicants and forwards only those resumés that match the employer's requirements.

Outreach

Through their outreach activities, marketers develop relationships with employers over time. Marketers are assigned businesses alphabetically and work with this set of employers. As a result, employers receive service from a consistent source and the marketers get to know the employers and the particulars of their businesses. Through these established relationships (the initiative is in its fourth year) the marketers come to know the hiring preferences of the businesses and are able to "look out" for the interests of the employers they support. This saves the employers time and money.

Trained and competent staff

Previously, staff who had responsibilities for approaching employers were community or social services workers who lacked business expertise and therefore credibility with the business community. BCES has enhanced its credibility by establishing a business-oriented marketing group and by providing high quality services.

Benefits to the Partner Organizations

Improved access to labour market for OW participants and EI clients

As a result of outreach and networking, the number of available jobs posted for both groups has increased steadily. In the first year of the partnership, there was a 90% increase in the number of job vacancies posted at HRDC over the previous year. Since then, the goal of a 10% increase per year has been achieved or exceeded. Ontario Works-Brant has been able to meet its Employment Placement job placement targets, in part as a result of this partnership.

Increased efficiency and effectiveness

Before this partnership, City and community staff "fell over" each other in approaching employers for job vacancies for their respective clients. Program and training dollar allocations were sometimes under-spent – staff marketing their own agency's services would be unaware of subsidy programs offered by other agencies and would therefore give employers incomplete information. As well, the business community's confidence in these agencies was low due to the restrictive nature of their programs, sporadic funding, and "red tape" they had to cut through to access programs.

In keeping with BCES' goal that employers take advantage of the training and employment program dollars available to them through community agencies, the Marketing Team regularly gathers information from these agencies so that they can in turn inform employers. As a result of BCES' co-ordinated approach to employers, program dollars are being utilised more effectively.

Lessons Learned

This initiative emphasizes that it is not the organizations but the people in the organizations who determine whether a partnership will succeed and what direction it will take.

Impasses may occur if there is no agreement on common program principles. For example, HRDC was moving toward a self-service model for all their clients (unemployed people and employers); Ontario Works-Brant took the position that employers who are provided with services would be more likely to list their job vacancies. The decision to involve politicians at this point led to a successful compromise. The lesson learned was that it takes time and commitment from senior levels to work through philosophical differences and to develop an approach that meets all partners' needs.

Key Success Variables

- strong leadership from partner organizations
- trust between the partners
- a business approach, with a strong results focus
- communication with, and involvement of front line staff
- knowledge of who the client is
- understanding what the business should focus on
- support at the senior management and political levels
- visible support for new ways of doing business by senior management
- evaluate marketing staff on achievement of results

Challenges

Keeping the initiative on track

During implementation, there were changes in senior management with resulting changes in assumptions about how the initiative should be designed. It was necessary to involve politicians when staff of the partner organizations were unable to reach agreement regarding a change in direction for the initiative.

It was also necessary to build in check-points to confirm direction and commitment to the initiative.

Maintaining a business approach

Developing and maintaining staff commitment to a business approach and results-oriented environment has been addressed in several ways:

- The Marketing Team develops a business plan for itself each year.
- New expectations are clearly articulated and regularly reinforced.
- Staff with a compatible orientation and the necessary skills are recruited.
- Training is provided for any new skills that are required.

Supervising staff who formally report to another organization

The two orgnizations have regular check-in points as well as opportunities for informal discussion.

Future Directions

The partners will review recent HRDC labour force data and focus employer recruitment efforts on new market areas.

History of the Initiative

A variety of concerns prompted the particular service delivery model that was adopted:

- Many community agencies were marketing their individual programs to the same *(favourite)* employers.
- Government employment and training subsidy programs were sporadic, restrictive, and involved a great deal of "red tape", a disincentive for employers to use them.
- Community agencies had worked in a co-ordinated fashion over many years to develop a comprehensive system of employment preparation and training programs in the County but were not effectively marketing these job-ready clients to employers.

The partnership initiative arose out of a need to develop a co-ordinated approach to working with employers. In the Fall of 1996, discussions began between managers in the City of Brantford and HRDC about the possibility of forming a partnership. Each party had reason to want a partnership:

- Job vacancies in the County were declining.
- HRDC was concerned that it would lose contact with employers as a consequence of the downsizing and restructuring which it was about to undergo. HRDC needed to maintain its capacity to reach employers in order to find work for EI recipients but would no longer have the staff to perform this function. However, HRDC could contract for this function.
- OW was being introduced. This created pressure on the City to find employment opportunities for OW participants.
- Through its job development efforts, Brantford was aware that employers wanted to deal with a single organization regarding recruitment rather than multiple orgnizations (HRDC, VRS, Youth Employment Centre, Mohawk College, Municipal Employment Programs, etc.).

There was an initial agreement between HRDC and the City of Brantford to create a jointly-sponsored Marketing Team. The team would systematically contact every employer in the County (4,000 at the time) to search for job opportunities. The goals were to increase the number of job vacancies posted through HRDC as well as to improve the fit between employers and potential workers by providing supports to both employers and job-seekers. Each partner contributed 50% to the partnership in financial and/or human resources.

The HRDC philosophy shifted: All HRDC services to employers and job seekers were to move as close as possible to self-service. If this approach were adopted, it would mean that services provided by the Marketing Team to employers, such as pre-screening of resumés and applicant pre-testing, would be discontinued. HRDC also wanted the BCES Marketing Team, which was made up of City staff, to have HRDC staff representation.

Earlier decisions were revisited and it was unclear whether or not the partnership would be maintained due to the difference in values. At this point, politicians from each organization became involved and it was agreed that:

- HRDC would assign a staff person to the Marketing Team,
- an Order Service team working at HRDC would receive and process job orders, and
- OW staff would provide additional services (i.e., pre-screening, testing) to employers and HRDC would not fund these "additional" services.

The City considered the provision of the broader range of services to employers an important support to employers that would lead to an increase in the number of job postings. This has turned out to be the case. Consequently, the City has continued to provide these services. The new arrangement has proved successful and the integrated Marketing Team has become increasingly cohesive over time.

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3. City of Kingston

LITERACY SCREENING AND ASSESSMENT FOR ONTARIO WORKS PARTICIPANTS

Partnership between City of Kingston and Kingston Literacy

Synopsis

Objectives of the Project –

- To demonstrate the value of conducting literacy screening assessments as part of training plan development for OW participants who may have low literacy skills,
- To identify and overcome any barriers that exist to the referral of OW participants to literacy upgrading programs, and
- To develop tools and establish protocols for the literacy screening and assessment of Ontario Works participants and to ensure appropriate referrals.

Partnership – The project is being carried out through a partnership between City of Kingston Ontario Works and Kingston Literacy.

Approach – A Project Co-ordinator/Worker was hired by Kingston Literacy to train OW staff and provide them with tools to screen OW participants for low literacy and numeracy skills. OW participants who have literacy barriers are referred to the Project Co-ordinator/Worker for in-depth literacy and numeracy assessment. Services are provided to participants at the location most convenient to them.

Challenge – The screening tool that is developed needs to be simple to use, brief, and effective in identifying the need by a participant for a literacy assessment.

Benefits – Participants are assessed for literacy in a non-stigmatizing setting and in the larger context of education and skills assessment. OW staff are in a position to refer participants with low literacy skills for a literacy assessment and remedial assistance, if required. By improving the literacy and numeracy skills of OW participants deficient in these areas, the OW program will become more effective in assisting them to move to employment.

Context

In its role of CMSM, the City of Kingston Social Services Business Unit is responsible for the management and delivery of OW and Child Care services within the geographic area of the City of Kingston (population 113,000) and the Townships of Frontenac (population 21,300).

An Ontario Works and Child Care office is centrally located in Kingston. As well, an OW Resource Centre is co-located with Human Resources Development Canada (HRDC). To facilitate service provision for people who live in the Townships of

Frontenac, an OW Child Care office and Resource Centre is co-located with North Frontenac Community Services in Sharbot Lake.

Rationale

In the past, OW case managers rarely referred OW participants to literacy programs. It was believed that people who could benefit from literacy assessment or programs were embarrassed to be seen going into a literacy centre.

The leaders of this project believed that if literacy screening and assessment were provided in the context of a more general education and skills assessment, there would be greater take-up by OW participants. The Initial Literacy Screening Assessment and OW Project is attempting to create such a non-stigmatizing environment where literacy and numeracy barriers experienced by OW participants are addressed in a broader educational context.

Project Objectives

The objectives of the project are to:

- demonstrate the value of conducting literacy screening assessments as part of training plan development for OW participants who may have low literacy skills,
- identify and overcome any barriers that exist to the referral of OW participants to literacy upgrading programs, and
- develop tools and protocols to support a seamless screening, assessment and referral process that has the support of both OW and literacy delivery agencies in our community.

Partnership and Linkages

The Initial Literacy Screening Assessment and Ontario Works project is being carried out through a partnership between the Ontario Works offices for the City of Kingston and Kingston Literacy. These organizations view the project as a logical next step in developing their relationship and in providing needed services.

Kingston Literacy is a community literacy provider and a member of the area Literacy Service Planning Group (LSP). In addition to Kingston Literacy, community partners in the LSP include the Algonquin Lakeshore Catholic District School Board, Limestone District School Board and St. Lawrence College. Through the LSP, Kingston Literacy will provide regular updates on the project to its literacy partners. As well, the Project Worker/Co-ordinator has monthly information sharing meetings with literacy assessors from the above-named organizations. These two groups (the LSP and literacy assessors) provide opportunities to keep the literacy partners informed of ongoing developments.

Roles and Responsibilities

The key players in this project are the:

- Executive Director of Kingston Literacy and the Manager of Program Delivery for the City of Kingston, Social Services, Ontario Works, who monitor the project,
- Project Co-ordinator/Worker, who reports to the Executive Director of Kingston Literacy,
- Program Integrity Officer, Ontario Works, City of Kingston, who is responsible for facilitating social services staff training, and
- front-line Ontario Works staff, who are responsible for the initial screening of OW participants for low literacy skills.

The specific responsibilities of the Project Co-ordinator/Worker include:

- preparing a literacy information kit for OW staff,
- developing a literacy/numeracy screening tool for use by OW staff,
- training OW staff in the use of literacy screening tools for the purpose of screening OW participants for low literacy skills,
- adapting assessment tools currently used by literacy assessors,
- providing ongoing literacy/numeracy assessment for those participants identified by OW staff as being potential literacy upgrading candidates,
- referring assessed clients to appropriate programs/services,
- maintaining statistics and keeping records of assessments and referrals,
- liaising with local literacy delivery agencies, and
- overseeing the final evaluation and writing the final report.

Committees

A core group was established specifically for this project to plan and manage its progress. This group includes the Executive Director of Kingston Literacy, the Manager of Program Delivery for the City of Kingston's Social Services/Ontario Works Business Unit, the OW Leader, OW Program Integrity Officer, Employment Services Co-ordinator and the Project Co-ordinator/Worker.

An OW front-line staff committee will meet as required to share information and engage in problem-solving.

Benefits

As this project is in the early stages of implementation, benefits have not as yet been realized. Expected benefits for clients, staff and the partners are described below.

Benefits for Clients

Anticipated benefits for OW participants include:

- They will have accurate knowledge of their literacy skills before they begin training, schooling or literacy upgrading.
- More adults will gain literacy skills.
- It will be less stigmatizing to be assessed for literacy in the context of education and skills assessment than to have to go to a literacy centre.
- It will be less stressful to be assessed in a familiar environment.

Benefits for Staff

Anticipated benefits for OW staff include:

- Staff will have the orientation and tools to screen OW participants for low literacy skills and then to refer for a literacy assessment.
- Staff will have the information necessary to provide more effective and appropriate guidance to OW participants.

Benefits for the Organizations

Anticipated benefits for the OW program include:

- The program will be more effective in assisting people to move to employment.

Anticipated benefits for literacy providers include:

- Kingston area literacy providers from all three sectors will experience better use of their services.
- Literacy assessors throughout Canada will have access to information about the screening and assessment tools developed in this project.
- The project will create a model for co-operation between literacy programs and OW.

Challenges

Developing a Simple Screening Tool

In the context of rapid change for OW staff, the challenge is to present this project in such a way that it is viewed by staff as a help, not a hindrance, to their work. Staff are always looking for tools they can use to assist their hard-to-serve clients, including those with literacy barriers. The intent is to include OW Case Managers in the development of the screening tool to ensure that what is developed is simple and fast for them to use, and at the same time effective in identifying the need for a literacy assessment referral.

Determining When to Use the Tool

Another challenge relates to determining at what point in the process it is most appropriate to screen OW participants for low literacy skills. At the initial appointment, the primary focus is determining eligibility for assistance, completing the Participation Agreement and orienting the individual to OW. Referrals for literacy services will take place at subsequent meetings, as barriers are identified, unless the participant self-identifies at the first visit as needing such services.

History of the Project

The City of Kingston (Department of Ontario Works) and HRDC jointly operate an Employment Resource Centre. For the past year, Kingston Literacy, a community agency that acts as a referral centre for literacy services, has also been co-located in the Resource Centre, sharing information with EI recipients, OW participants and the general public. Kingston Literacy has also conducted preliminary training sessions for OW staff to help them identify OW participants who have literacy/numeracy barriers.

With the support of all the literacy service providers in the area, a project application was submitted by LSP to the Workplace Preparation Branch, Ministry of Education and Training. Funding approval for an eight-month pilot was given in June 1999, with the expectation that the project would be well underway in early 2000.

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4. City of Toronto

ADDRESSING HOMELESSNESS WITHIN AN ENVIRONMENT OF MUNICIPAL RESTRUCTURING

Synopsis

Goal – To address issues related to homelessness in a more integrated and systematic fashion throughout the amalgamated City of Toronto.

Approach –

- An interdepartmental working group on homelessness co-ordinates activities related to homelessness.
- The City of Toronto Homeless Initiatives Fund (CT-HIF) was established to enhance the City's response to homelessness and to provide a mechanism for responding to the recommendations of the Mayor's Homelessness Action Task Force. This Fund supports a range of projects designed to address homelessness.
- The City has developed a Housing First Policy that gives priority to the development of affordable housing.

Challenges – Homelessness issues are being addressed in an environment that has recently changed significantly as a result of municipal amalgamation. Other challenges include developing a common organizational culture, managing competing priorities within a context of limited resources, and managing a complex set of programs and services.

Benefits – A more co-ordinated approach is being taken to address homelessness across the City.

Context

The Greater Toronto Area (GTA) is one of the fastest growing regions in the country. The City of Toronto accounts for 2.4 million people, just over half the population of the GTA.

The devolution of human services and the amalgamation of the seven former municipalities have given the City a much wider range of responsibilities.

This case study describes aspects of the restructured municipal government as they relate to the integrated approach being taken to homelessness in Toronto.

Organizational Structure

Six New Departments

When the City of Toronto's municipal government was restructured, the organizational structure of seven former municipalities was brought together in six new departments:

- Community & Neighbourhood Services
- Economic Development, Culture and Tourism
- Urban Planning & Development Services
- Works & Emergency Services
- Corporate Services
- Finance

The six Commissioners of these new departments report to the Chief Administrative Officer who is accountable to Council.

Community & Neighbourhood Services Department

The Community & Neighbourhood Services Department has the lead role in the City of Toronto for co-ordinating the City's response to homelessness.

Five divisions report to the Commissioner of this Department:

- **Shelter, Housing and Support Division** – Ensures that vulnerable people have a range of shelter and affordable housing options. Provides temporary shelter and support for homeless individuals and families while working to create and maintain permanent housing solutions.
- **Social Development Division** – Works with other divisions within the Department, other levels of government and the community to develop strategies, policies and programs that meet the City's community and social service needs.
- **Children's Services Division** – Promotes and delivers quality child care by providing subsidized child care spaces across Toronto.
- **Homes for the Aged Division** – Provides long term care for people who can't live independently in the community through 10 directly operated homes and supportive housing at contracted sites. Offers services that enable people to remain in their own homes as long as possible.
- **Social Services Division** – Manages the social assistance system and offers a wide variety of programs and services designed to promote client independence.

The Chief Operating Officer of Toronto Housing and the Medical Officer of Health (MOH) report to the City Housing Board and the Board of Health, respectively, but work through the Commissioner on matters such as the budget and major policy issues that cut across other divisions.

- **Toronto Housing** – Provides affordable housing for seniors, families and single people with low to moderate incomes. Offers a wide variety of housing options at market rents as well as one-stop access to social housing across Toronto. A Board of Directors is responsible for managing Toronto Housing.
- **Medical Officer of Health** – On strictly public health issues, the MOH reports to the Board of Health. For public health issues that overlap with the mandate of another division, the MOH still reports to the Board of Health but also through the Commissioner to the Community Services Committee, Council's Standing Committee dealing with social issues. For example, where Public Health has the lead (e.g. issuing health cards to homeless men), recommendations are developed jointly with the Social Services Division and the Shelter, Housing and Support Division. Recommendations are made to the Board of Health as well as through the Commissioner, to the Community Services Committee.

Addressing Homelessness

Prior to the restructuring of the City's municipal government, only two municipalities were involved in homelessness issues to a significant extent: Metro and the former City of Toronto. A range of services was provided to homeless people and those at risk of homelessness, including emergency shelters, social assistance, child care and public health-related services. For example, to meet the needs of shelter residents, the Children's Services Division operates a child care program within a family residence. The child care workers' hours have been extended to accommodate people who work shifts, who work part-time and who are looking for work or permanent housing.

The availability and level of particular support services varied across municipalities. With restructuring, and in response to the report of the Mayor's Homelessness Action Task Force (see below), homelessness is now being addressed in a more integrated and systemic fashion throughout the City of Toronto.

Report of the Mayor's Homelessness Action Task Force

Homelessness levels in Toronto have increased in recent years with more people living on the streets and using shelters. As a result, the pressure on drop-in centres, food banks and other emergency services is increasing as well. In response, the Mayor's Homelessness Action Task Force was created in January 1998 to:

- recommend solutions to the increase in homelessness, and
- respond to public concerns about its increasing visibility.

MANDATE

The mandate of the Task Force was to develop both short-term proposals for emergency services and long-term solutions for health and mental health services, housing support, housing supply and housing affordability. In January 1999, the Task Force presented the Mayor with its final report entitled "Taking Responsibility for Homelessness: An Action Plan for the City of Toronto."

POLICY RECOMMENDATIONS

The Task Force report contains 105 recommendations directed to all levels of government and the community-based service sector. The Task Force proposed an action plan with six key strategies to address the major barriers to reduce homelessness:

Reduce poverty: Adjust the shelter component of social assistance to reflect local market conditions and create a shelter allowance program for the working poor.

Preserve and create new affordable and supportive housing: More supportive housing is needed for homeless people with mental health issues or addictions. A housing strategy is needed, involving each level of government, that focuses on preserving the existing affordable supply and creating new housing.

Shift the focus from emergency to prevention responses: Strategies such as a rent bank for short-term arrears and one-on-one support to help people move from shelters to stable housing are key to preventing homelessness.

Plan services and develop strategies for high-risk groups: At the service level, co-ordinated planning is needed that meets the needs of different groups, e.g. youth, families, singles.

Implement a comprehensive health strategy: A comprehensive health strategy is required to care for the physical and mental health of people who are homeless.

All levels of government must work together: Each level of government must take responsibility for the homeless crisis and commit itself to developing solutions.

City of Toronto's Response to the Task Force Recommendations

The Mayor requested the Commissioner of the Community and Neighbourhood Services Department to prepare an action-oriented response to the report. As the recommendations contained in the report have implications for several of the City's departments, an inter-departmental team was established to develop the City's response, co-ordinated by the Shelter, Housing and Support Division of the Community and Neighbourhood Services Department. Two complementary activities include:

- the City of Toronto Homelessness Initiatives Fund (CT-HIF), which supports a range of initiatives designed to address homelessness, and

- a Housing First Policy regarding the use of city lands.

City of Toronto Homeless Initiatives Fund (CT-HIF)

This Fund combines the City's Homeless Initiatives Fund, which was created in 1992, and the Provincial Homelessness Initiatives Fund, which was established following the release of the report of the Provincial Task Force on Homelessness in 1998, into one program with a common application, selection and evaluation process. A Request for Proposals (RFP) was issued by the City in June 1999; a second RFP was issued in the fall of 1999. The CT-HIF is managed by the Shelter, Housing and Support Division.

The CT-HIF provides the City with a mechanism for responding to homelessness across the City and to the recommendations made by the Task Force. The intent of the CT-HIF is to expand the City's response to homelessness across the City by:

- funding a broad range of new initiatives that have a measurable impact on preventing homelessness,
- helping people access emergency shelters or moving them from hostels into more permanent forms of accommodation, and
- freeing up space within the shelter system.

Reporting requirements are built into initiatives which received funds from the CT-HIF and the City will be monitoring this information. The City is working towards improving and refining its capacity to evaluate the effectiveness of initiatives funded as part of the CT-HIF.

The funding criteria for this program are shown in Exhibit 1, on the next page. Refer to Appendix A, in this section, for a chart depicting the types of initiatives that are funded by the CT-HIF and the homeless sub-groups they target.

Housing First Policy

City Council adopted the Housing First Policy following the release of the Task Force report. Whenever a building or vacant lot that is owned by the City is declared surplus, the Shelter, Housing & Support Division is given the opportunity before anyone else to determine whether it is appropriate for the development of affordable housing. If it is deemed unsuitable or cost-ineffective for housing, other departments then have an opportunity to determine whether the surplus property might be suitable for their purposes or whether it should be sold.

Exhibit 1: CT-HIF Funding Criteria

The City's agreement with the Province specifies that funds are to be used for new, innovative community-based programs that achieve one or more of the following outcomes:

1. assists people to move from the streets to emergency accommodation,
2. assists people to move from emergency to permanent accommodation, and
3. prevents homelessness by supporting the retention of stable accommodation.

The City gives priority to:

1. strategies which result in longer term solutions to homelessness,
2. projects which create efficiencies elsewhere in the system of services to homeless people,
3. direct services to homeless people or those at risk of homelessness,
4. inclusion of homeless people in projects through employment and in the planning, implementation and evaluation stages, and
5. qualitative and quantitative evaluation methods to ensure that the program meets its goals and objectives and that individual projects are effective.

Co-ordination of Homelessness Activities

Given the size of Toronto and the scale of programs and services, it is not considered feasible, or desirable, to take a case management approach to integration. Rather than aiming for "single window access" to services, the objective is to ensure that services are co-ordinated, that people understand how to access services, and that communication is effective within and across departments. Linkages within the City's organizational structure and with external groups and organizations support co-ordination, for example:

- The Shelter, Housing and Support Division has established an intra-departmental committee to ensure that strategies developed to address homelessness issues take into account the needs of a variety of clients and that they are consistent with work underway in other parts of the Department.
- An inter-departmental work group on homelessness includes representatives from various divisions within the department as well as staff from the Urban Planning & Development Services Department and Office of the Chief Administrative Officer.

- The Shelter, Housing and Support Division itself is a mechanism to promote integration. In the former municipalities, housing, shelter and support services were separate. The division creates a core of housing/homeless services.

Two formal mechanisms link to the community:

- An Advisory Committee on Homelessness and Socially Isolated Persons, co-chaired by a municipal politician and a representative from the community, meets formally each month to provide an opportunity for the community to raise concerns and have a voice in the City's process. The recommendations of the Advisory Committee are forwarded to Council.
- A reference group, the Alternative Housing and Services Committee, assists staff to develop grants and service planning policies. This Committee holds monthly information-sharing forums which focus on the City's responses to homelessness.

The Toronto Homeless Community Economic Development Program

This collaborative initiative, which was announced in January 2000, involves four funders: the City, the United Way of Greater Toronto, the Ministry of Community and Social Services and HRDC. It will support community economic development projects for the homeless and those at risk of homelessness in Toronto. The program will fund locally-run small projects that involve this population in ventures designed to build life and work skills, develop self-esteem and link them with available community services.

The Toronto Report Card on Homelessness 2000

The City has prepared a report that describes changes in the profile of homelessness in Toronto and the causes of homelessness. It also describes actions taken by the three levels of government in relation to the Mayor's Task Force recommendations.

Challenges

Competing Policies and Priorities

At times, particularly in an environment where resources are limited, the policies and priorities of different departments or divisions within the Community & Neighbourhood Services Department compete with one another. For example, on occasion, the needs of the Parks Division conflict with the principles of the Housing First policy. Efforts are made to resolve such issues at the administrative level. However, in the event that issues can't be resolved, they are addressed at Council.

Similarly, in an environment of fiscal restraint, there is more competition among high priority areas for resources. For example, the resources required to cope with a

significant increase in demand for emergency shelter may have to be taken from other areas which are also high priority, creating additional stress in the system.

Developing a New Organizational Culture

Amalgamation has brought together seven municipalities, each with its own culture, policies, and procedures. A new organizational structure has been created and reporting relationships have changed. Within the context of these changes, and the associated uncertainty, it is sometimes difficult to effectively manage the service system.

Adopting a Broad Perspective

In an environment where staff are in the early stages of understanding how the new configuration of programs is expected to operate and what the impact of the new structure will be on individual roles and responsibilities, staff need time and support in order to expand their focus beyond their immediate responsibilities to a comprehensive view that encompasses other programs and services.

Managing the Service System

Service system management is a complex undertaking. It requires the service system manager to engage in an array of tasks such as: assess needs, identify service gaps, manage resources, evaluate outcomes, direct resources to where they have the greatest impact, advocate for more and/or different services, support community groups, manage a service system with community partners, collaborate with other funders, understand the issues and the ways in which they manifest themselves for different people with different needs, link with other service system managers across the GTA and elsewhere, and engage in research-related activities.

As the service system manager for homelessness, the City requires flexibility to manage the system as well as predictable funding for it community projects.

Benefits

A number of benefits of restructuring were identified for both clients and staff. Some of these benefits are specific to homelessness-related issues while others are more generally applicable.

Benefits for Clients

Benefits for homeless people and for those who are at risk of homelessness include:

- A more streamlined approach is being taken to getting clients into the system.
- There is less bureaucratic "red tape".

Benefits for Staff

- For senior management, a greater degree of integration makes it easier to co-ordinate the allocation of resources.
- Front-line staff are more likely to see the benefits of integration directly when, for example, they collaborate on providing services such as child care to enable residents in shelters to find or keep jobs.

Benefits for the Organization

- Messages from corporate to advocates and community agencies are more consistent. With a more integrated approach being taken corporately, there is less likelihood of multiple competing messages.
- For the City, a more co-ordinated approach is being taken to homeless issues as they relate to housing, income, health, employment and child care needs. The information City Counsellors and the Mayor receive about homelessness issues is better co-ordinated, with more opportunities built-in at the administrative level to problem-solve and develop solutions.
- With one public health department for the entire City, there are more opportunities for co-ordination. For example, when the Medical Officer of Health calls a weather alert, there is better co-ordination of efforts with hostels and community agencies that engage in related activities.
- The press has been more positive in their coverage of what is being done to address issues related to homelessness.

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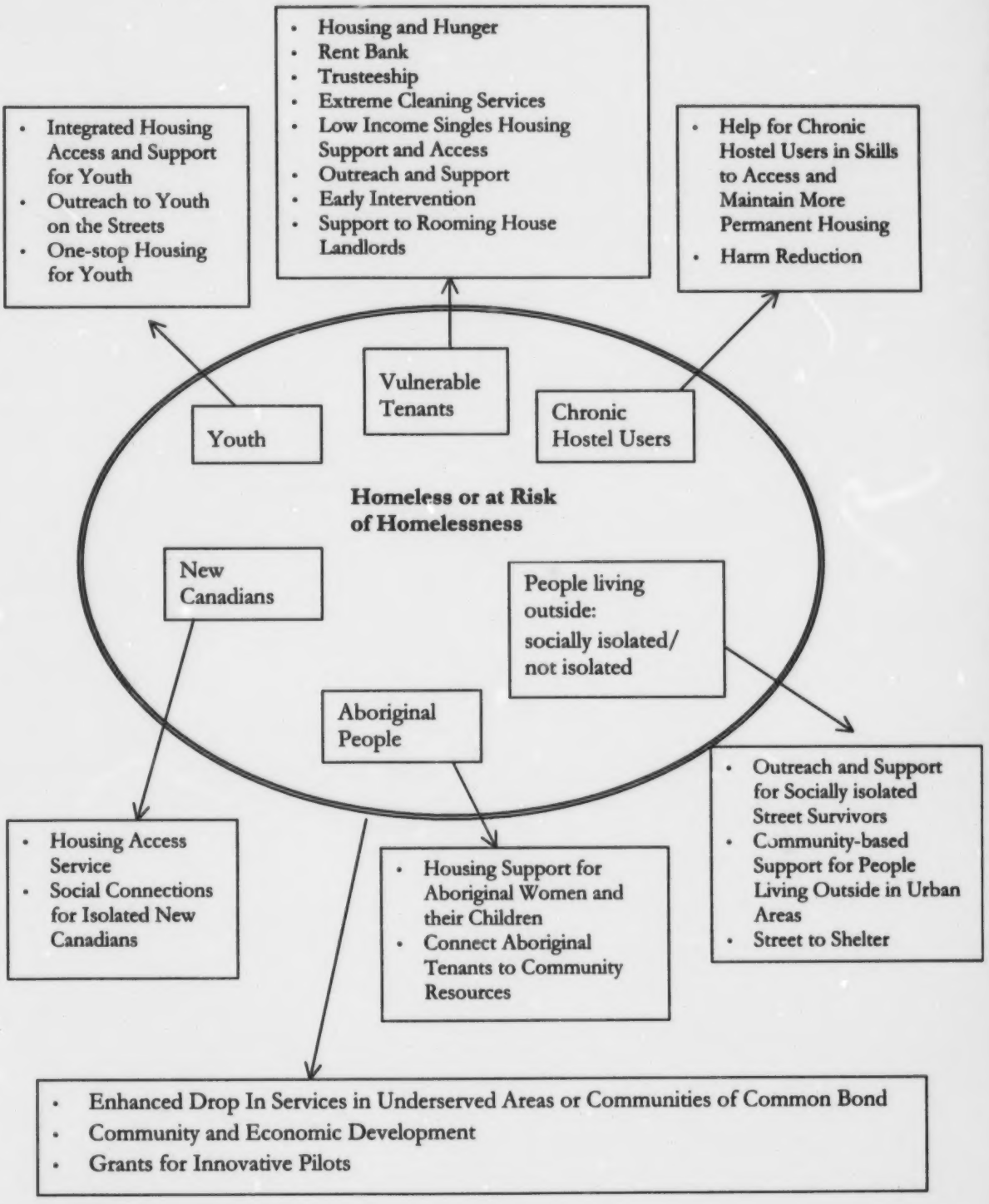
Appendix A

City of Toronto Homeless Initiatives Fund


Housing and Hunger
Rent Bank
Trusteeship
Extreme Cleaning Services
Low Income Singles Housing Support and Access
Outreach and Support
Early Intervention
Support to Rooming House Landlords
Integrated Housing Access and Support for Youth
Outreach to Youth on the Streets
One-stop Housing for Youth
Help for Chronic Hostel Users in Skills to Access and Maintain More Permanent Housing
Harm Reduction
Vulnerable Tenants
Youth
Chronic Hostel Users
Homeless or at Risk of Homelessness
New Canadians
People living outside: socially isolated/ not isolated
Aboriginal People
Housing Access Service
Social Connections for Isolated New Canadians
Housing Support for Aboriginal Women and their Children
Connect Aboriginal Tenants to Community Resources
Outreach and Support for Socially isolated Street Survivors
Community-based Support for People Living Outside in Urban Areas
Street to Shelter
Enhanced Drop In Services in Underserved Areas or Communities of Common Bond
Community and Economic Development
Grants for Innovative Pilots

5. Cochrane DSSAB

OW Integrated Case Management

Synopsis

Goal – To create a single point of access for OW participants.

Approach – Timmins integrated two distinct functions -- income support and employment support -- that had previously been carried out by different staff into one staff position called a Case Manager. In addition, an employment specialist function was retained in the form of Employment Resource Workers.

Benefits – OW participants can relate to one person for both their financial and employment support needs.

Challenges – The need to be an employment facilitator as well as an "OW cheque cop" represents a significant change. Some staff who had previously never worked in the area of employment support felt they lacked the necessary expertise. To address staff concerns, supports need to be provided during the transition period. A challenge for the organization is developing an employment-focussed culture.

Context

The Cochrane DSSAB encompasses several separated cities including Timmins, Cochrane, Kapuskasing, Iroquois Falls, Hearst and Moosonee as well as unincorporated communities. The total population is about 90,000. The largest concentration of people is in Timmins which has a population of about 50,000.

Organizational Structure

The DSSAB's corporate office is located in Timmins. There are satellite offices in 5 other communities: Cochrane, Iroquois Falls, Kapuskasing, Moosonee and Hearst. Four managers report to the CAO: 3 OW Program Managers and a Manager of Community Services and Operations.

Two OW Program Managers are based in Timmins where they manage staff including Case Managers, Employment Resource Workers, Eligibility Review Officers, Family Support Workers and case aides/clerks. Staff who service Moosonee report to one of these managers. A Child Care Manager, Child Care Co-ordinator and operational staff (e.g. Accounts Clerks, Receptionist) report to the Manager of Community Services and Operations in Timmins.

The Cochrane-based OW Program Manager oversees staff based in the 5 satellite offices.

Initial Challenges

Challenges initially facing the Cochrane DSSAB included:

- achieving a consolidation agreement,
- dealing with the distances between communities in the District, and
- integrating the employment support function into the case manager role in Timmins.

A vision and values statement for the DSSAB, as well as a policies and procedures manual are currently being developed.

Social Assistance Delivery

Prior to consolidation, the City of Timmins and the Cochrane District Welfare Administration Board (DWAB) administered GWA. The Province was responsible for delivering GWA for Moosonee and unconsolidated areas within the District. The OW caseload for the Cochrane DSSAB is currently about 2,800. Prior to consolidation, the caseload to worker ratio was 250:1. Since then, additional staff have been hired to bring that ratio to about 133:1.

Prior to consolidation, Timmins was one of the first sites in the province to deliver OW, beginning in October 1996. (At that time, the functions of Income Maintenance and Employment were separate.) The other OW sites in the Cochrane DWAB were established in late 1997. In these sites, an integrated case manager role was established at the outset.

Approach

Goal of Integration

The goal of integrating income support and employment support was to create a single point of access for clients so that they could relate to one worker for both components of OW.

Implementation in Timmins

OW was implemented in Timmins before integrated case management became a focus. Timmins is the only site within the DSSAB where there had been two separate staff groups responsible for income support testing and employment support. On February 1, 1999, consolidation occurred and in April 1999 an integrated OW/case management model was implemented throughout the entire District.

In order to create an integrated Case Manager position, a consolidated job description was developed. Salaries of the Income Maintenance Worker and the Employment Support Worker were comparable previously so this was not an issue and a new salary for this position did not need to be established. Neither were there any union issues.

The absence of union issues is attributed in large part to effective communication between the CAO and union officials. The CAO met with union officials throughout the transition period to keep them apprised of developments and to respond to concerns.

Communication with OW Participants

Cheque inserts were the main vehicle used to inform participants about changes to OW delivery. This was supplemented with an information package that provided additional information about the integrated approach being taken to case management. As well, notices were posted on bulletin boards in all offices.

Staffing Model

Case Managers are responsible for determining the eligibility of OW applicants for financial assistance, and for completing Participation Agreements and employability assessments with OW participants. Prior to integration, most staff who are now in Case Manager positions had backgrounds in income support.

Ongoing support is being provided to Case Managers to help them make the transition to a more integrated approach to case management. For example, in the three weeks prior to the interview for this case study, designated DSSAB staff scheduled one hour every day with Case Managers to answer their employment support-related questions, including those related to OW technology, and to provide information about community resources and referral possibilities.

Management is currently developing a training plan to address the need for Case Managers to augment their employment support skills.

An employment specialist function was retained in the form of Employment Resource Workers (their position title was previously Employment Support Workers). Prior to the integration of OW case management in Timmins, two Employment Support Workers were co-located with HRDC in an HRDC office. The primary responsibility of these workers was to complete client employability assessments. They also made referrals to community services. OW participants had to go to the HRDC office for their employability assessment and to an OW office for eligibility assessment.

Due to changes at HRDC and an opportunity that arose for the Timmins office to have its own resource centre on site, the two Employment Support Workers were moved to the Timmins office, at which time their position title also changed.

The responsibilities of the Employment Resource Workers at the resource centre alternate on a weekly basis. One week, one worker interacts directly with participants, conducting orientation sessions and helping them to access technology, prepare resumes, conduct labour market research, and access the job bank. That same week, the second worker focuses on matching community placements, working with community resources, and compiling reports. The next week, the two Employment Resource Workers switch responsibilities. This gives the workers a wider range of skills and allows them to be flexible in response to changing pressures on the job.

Benefits

Benefits for OW Participants

Anecdotal comments from participants suggest that these changes are viewed positively and that they like interacting with a single worker. Also, prior to integration, OW participants had to go to two different locations for services: the HRDC office to meet with their Employment Support Worker and the Timmins office for income support-related matters. They now go to one location for both.

Benefits for the Organization

The co-location of Employment Support Workers in the HRDC office created significant communication and supervisory challenges for the Timmins office. With all staff now under one roof, these issues have been resolved. For the whole District, technology (e.g., e-mail) lends itself to improving communication between satellite offices and corporate, helping to ensure that staff across the District hear the same messages.

Role of the Board

Board members have been very supportive of the work of the CAO and management. They have expressed confidence in the judgement of the CAO and are satisfied to let him manage the organization.

Lessons Learned

Challenges for Staff

The move to integrated case management presented a significant challenge to Case Managers (who were previously Income Support Workers, for the most part) during implementation:

- Although staff are getting used to their new role, they find it difficult to balance time spent on the two components of OW. They would like to spend more time on the employment support role but find that the income support component consumes a great deal of their time and energy.
- Staff who had previously never worked in an employment focused environment felt they lacked the necessary knowledge. Because of their background, they require ongoing support/training to acquire the skills needed to fulfil the employment support component of their jobs.
- The need to be an employment counsellor/facilitator as well as an "OW cheque cop" required a significant change in attitude.

Strategies

Address staff insecurities and concerns

Since the staff who were to become Case Managers had not, for the most part, previously worked in an employment-focused environment, they felt insecure about their ability to perform the dual role. Their need for support is being addressed in several ways: daily consultation periods with Employment Resource Workers, weekly team meetings, open door policy of manager. This strategy reflects management's commitment to support staff and respond to concerns they identify quickly. A "quick fix" strategy is also in place whereby issues related to legislation or OW policy directives, for example, are responded to quickly.

Involve the union

There has been no opposition to the newly integrated role on the part of the union. The positive response from the union resulted from the ongoing communication that took place between management and the union throughout the planning and implementation process.

Acknowledge and ease the shift in culture

Case Managers had to make the shift from focusing on financial eligibility to working in a facilitating manner, such as helping participants to set employment goals. It is important to recognize that it takes time to bring about a change in culture, that it doesn't just happen. Training issues that arose in the course of changing people's roles were dealt with by developing an overall training plan. To help orient Case Managers, local organizations that provide employment-related supports were invited to make in-house presentations about their services.

Communicate with staff

Throughout the transition period, changes were communicated to staff on an ongoing basis. All staff are linked by e-mail. More significant issues are dealt with at weekly managers' meetings. Within teams, staff support each other, "buddying-up" to help resolve issues.

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6. Dufferin County

Dufferin County covers a geographic area with a population of approximately 50,000 people. Within its catchment area there are three towns (Orangeville, Shelbourne, and Grand Valley) and five rural townships. Over half the County's population lives in Orangeville.

The economy depends in part on agriculture but the manufacturing, construction, and tourism sectors are growing.

Three integration approaches developed in Dufferin County are described in this case study:

- a partnership between Dufferin County, HRDC and Georgian College in a human resources centre,
- an information service that integrates information on health, social and municipal services, and
- cross-training between the County and the Local Housing Authority in governance and administration.

HUMAN RESOURCE CENTRE

Dufferin County, HRDC, and Georgian College Partnership

Synopsis

Approach – Dufferin County, HRDC, and Georgian College are partners in a Human Resource Centre (HRC) in which they share employment resources and a waiting area. Clients include OW participants, EI recipients, and youth as well as the general public. Georgian College delivers its programs, Job Connect and Job Opportunities for Youth, through 3 staff located in the open area of the HRC. Similarly, HRDC staffs a desk for the delivery of specific services for EI recipients. OW employment counsellors working with OW participants have a separate area outside of the common area.

Benefits – Staff in the three organizations are able to learn from each other. People who are eligible under more than one program can access all services in a single location. The approach has proven to be cost-effective and flexible for the partner organizations.

Target Groups

The Human Resource Centre (HRC) serves four groups: EI recipients, OW participants, youth and members of the general public.

Services

The HRC has a waiting area and an employment resource centre that are used by clients of all three partners. The resource area has a range of materials and equipment: clients have access to computers, the internet, printers, fax machines, photocopiers, and information. A career planning software package is also available for their use.

In-house workshops on resumé writing, career planning, interview skills, and job search strategies are also available to clients.

The Partnership

Costs are shared in proportion to the number of staff each organization contributes to the partnership. Larger cost components, such as rent, are covered by the federal and municipal partners. Georgian College contributes to the administrative costs.

Dufferin County contributes an employment counsellor and an administrative support person to the HRC. This individual works in the Centre 50% of the time and for the Ontario Works program the other 50%.

The partners also operate their own specialized programs -- HRDC and Georgian College in the open area of the HRC and OW in a private area :

- The Georgian College desk in the HRC is staffed with 3 full-time positions. The workers provide services under Job Connect, a program that targets unemployed 16 to 24 year olds and Job Opportunities for Youth, for those aged 18 to 30.
- HRDC has a desk in the HRC from which an HRDC worker provides specialized services, i.e., eligibility assessment of EI applicants.
- Two full-time OW employment counsellors provide specialized OW services.

The Georgian College workers provide assistance to other clients in the Centre if needed.

Clients

OW participants represent 25% of the people using the Centre, EI clients 50% and the general public 25%. The high percentage of EI clients is attributable to the mandatory workshops that these clients are required to attend. Members of the general public who use the Centre are believed to be at risk of unemployment, underemployed, or looking for a different job.

Accountability

When people come into the Centre, they are asked to complete a form on which they indicate whether they are EI clients, have been EI clients within the last 5 years (reachback clients[1]), are OW participants, or are 16 – 24 years of age.

[1] Clients who have received EI or were eligible to receive EI within the last 3 years, or parental benefits within the past 5 years.

Benefits

Benefits for Clients

Co-location allows employment counsellors in the three organizations to:

- share information, e.g., what works, alternative approaches,
- co-ordinate services between the organizations, for example,
  - OW can pay for child care and employment related costs for social assistance recipients.
  - Youth eligible for OW are referred to Georgian College staff for employment counselling under Job Connect and then referred back to OW for workshops.

Benefits for the Partner Orgnizations

The integrated approach has proven to be cost-effective and flexible. It has also helped to create a positive public image for the partners.

Lessons Learned

Success Factors

Get to know your partners through co-location.

Work toward integration in small steps.

Challenges

An integrated approach to service delivery presents challenges in maintaining accountability within funding streams.

Typically, the more funding partners, the more complicated integration becomes. For example, developing compatible organizational cultures and trusting relationships is more difficult.

History

Dufferin County has operated a municipal employment program since 1984. One employment counsellor helped social assistance recipients to prepare for and find work. The service was provided in space shared with other employment programs.

In 1992, some of these other programs moved out of the shared space. In order to remain viable, Dufferin County and a Canada Employment Centre decided to co-locate. This was seen as a first step, with the shared longer-term goal being to create an integrated service.

In 1997, Georgian College joined the HRC at the invitation of Dufferin County. The rationale was that the services to youth provided by the College would round out the package of services available at the Centre, and College staff would bring additional skills.

The number of clients receiving service in 1992 was approximately 200 per month. This number has increased over the years and, now, about 850 clients receive services each month.

Future Plan

To hire a full-time Job Developer who would approach employers and encourage them to hire clients of all three partners.

For further information, contact:

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DUFFERIN INFORMATION ACCESS LINK

Dufferin-Wellington-Guelph County Community Care Access Centre and Dufferin County Partnership

Synopsis

Approach – Dufferin County created an information line that provides community residents with access to information about a broad range of social and health services in the area. The information database is available to the public on CD-ROM.

Partnership – Dufferin County was selected to provide the single point of access to information on children's services and services for persons with developmental disabilities under the Making Services Work For People (MSWFP) initiative. One-time funding was provided by MCSS in 1999. The County decided to broaden the scope of the information line to include other social, health and municipal services. The County formed a partnership with the Wellington-Guelph-Dufferin County Community Care Access Centre (CCAC). The CCAC provided Dufferin County with the initial database. The County updates the database with service and resource information in its geographic area.

Benefits – The public will have access to up-to-date and accurate information about a range of social, health and municipal services. In the future, this database will be updated with information about additional services. The partnership has also fostered alliances between Dufferin County and other community agencies that participated in a reference group for the implementation of the information line.

Mission and Objectives

Dufferin Information Access Link (DIAL) provides residents in Dufferin County with information about and referral to a variety of government and community services.

The objectives are to:

- provide callers with a responsive service.
  - Callers will receive the telephone number (or contact information) for the service or program that addresses their expressed needs.

- maintain an up-to-date and accurate database of information
  - DIAL will develop processes to co-ordinate database updates.
  - Agencies will be responsible for updating their DIAL records when there are changes to the services they offer.

Partnership

There are two partners in the initiative: Dufferin County and the Community Care Access Centre (CCAC) for Guelph, Wellington, and Dufferin. Both partners update their respective versions of the database and cooperate in the monthly amalgamation of the information that is conducted by the United Way.

The Service

DIAL has two main features:

- a database that captures information about local social, health and municipal services, and
- an information line through which the community can access this information.

In the future, the database will be available to the public on CD-ROM, for a fee.

At this time, the database contains 1,100 records that include all the services funded by the province (Ministries of Community and Social Services; Health and Long-Term Care; Education; Agriculture, Food and Rural Affairs, etc.) and by the municipalities of Dufferin, Wellington, and Guelph. In addition, records include some leisure, self-help, recreation, and support services (such as pharmacies). The intent is to add or augment information on all types of services, particularly legal services, services for seniors, and leisure and recreation.

The Dufferin County website provides the DIAL telephone number. The County is planning an interactive web page that will include frequently called numbers, frequently asked questions, and hot links, plus telephone numbers for a variety of other sources of information.

The Database

Initially, Dufferin County hired a consultant to obtain information from the various human service organizations in the County and to enter that information into the database. A summer student in the Dufferin Social Services Department made extensive additions to the database on services that are available in the County. Dufferin County Social Services staff regularly monitor local newspapers and actively pursue information about changes or additions to local services, updating the database as necessary.

The CCAC has arranged for the United Way Community Services of Guelph and Wellington to create a new master disk that amalgamates new service information collected by the CCAC and Dufferin County. Each month, DIAL and the CCAC send their updated databases to the United Way. The updated master is sent back to the two organizations where each partner extracts the information that it includes in its own database. The CCAC retains only a portion of the Dufferin data. In this way, the CCAC and Dufferin County share limited information about the County but the DIAL database includes more comprehensive information on social, municipal and health services in Dufferin County.

The database will be maintained through regular updating by the partners. Dufferin County will conduct regular updates of the Dufferin records in the shared database. The database automatically indicates the time that the records are to be updated. DIAL plans to meet with all information and referral providers in Dufferin to co-ordinate updating of records. A summer student will be hired to continue the updating process by pulling out records that are due to be updated and sending these to the agencies with a reminder.

The Information Line

The toll-free information line is open weekdays from 8:30 to 4:30. Calls are usually answered by an Ontario Works case manager. The technical options purchased with the line include Call Log, Call Answer, and Call Direct.

When staff are not available to answer calls to DIAL, callers are directed to the Orangeville public library for information or they may leave a message if they wish to have their calls returned. Callers with an urgent medical issue are directed to call the Headwaters Health Care Centre.

A call log enables DIAL to monitor the volume of after-hours calls. If warranted, the hours during which the information line operates will be reviewed.

Resources

Staffing

Staff responsible for taking calls on DIAL report to the Supervisor of Dufferin County Social Services. Calls to the information line are usually received by an OW case manager. When the case manager is unavailable, calls are transferred to a data clerk in the department. All the OW case managers and the data clerk are trained to handle the incoming calls. When neither the case manager nor the data clerk is available, the calls are forwarded to the receptionist for the Social Services offices. If the person who takes a call does not have the necessary information, whenever possible, the call is transferred to another staff member who does. If a back-up staff cannot provide the answer to a caller's request, the caller's number is taken and a call back is made with the information requested.

Funding

ONE-TIME

MCSS covered the capital costs for the computers and the telephone system.

HRDC covered the costs of purchasing and developing the database, promoting the information line, and hiring a consultant/project manager.

ON-GOING

Dufferin County provides staffing support, technical support, office and in-kind supplies.

Funding to cover on-going costs of the telephone system is being pursued.

Benefits

The community has always been able to obtain some information about human services from the County. DIAL is value added because it has resulted in:

- an expanded base of information,
- a formal process for maintaining and enhancing the database, and
- a formalized approach to staffing the service.

Benefits for the Public

A principal benefit is that accessible, centralized information on a range of human services available in the county is available to the community and County staff. Information lines had been attempted previously but without targeted funds. Secure funding enables DIAL to provide a stable, quality service for the community.

Having telephone access to information about human services is particularly beneficial for seniors, who tend to be more isolated.

Benefits for the Service Providers

More opportunities were created for alliances between Dufferin County and other community agencies through participation in the Reference Group[2] which helped guide the implementation of DIAL. As other providers of information and referral are involved in the database updating process, there will be opportunities for additional linkages to be formed.

The experience that OW staff have had working with DIAL will prepare them to conduct telephone intakes for OW.

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[2] The reference group includes the Orangeville Public Library, Dufferin Human Resource Centre, Dufferin Volunteer Centre and Community Youth Services.

By providing good customer service, the County's public image is enhanced. This is beneficial to councillors and raises the profile of social services in a positive way at a corporate level.

Accountability/Monitoring

The telephone technology provides a log of calls, indicating the caller's telephone number, time of call, and whether the call was answered or not. This information is collected and analyzed each month.

DIAL is purchasing a call tracking program which will enable the workers to record information about the caller, including gender, area of residence, age, type of inquiry, referral source, and time spent on the call. This information, too, will be analyzed and reported each month. Relevant information, including gaps in service that are identified, will be shared with other service providers.

An evaluation plan has been developed to ensure that DIAL is effective and well-utilized. Call patterns and call usage will be tracked to determine the volume of calls and the types of information requested. As well, a customer satisfaction survey is planned. The focus will be on customer satisfaction, for example, was the service appropriate, was the service of high quality.

Lessons Learned

Use a generic approach – The County has kept a low profile. Marketing materials include the logos of each of the funders on the brochure, conveying the message that the information service is supported by a number of partners and is not a County social service. As a result, it is expected that DIAL will not be "stigmatized" as a social service.

Be creative in finding funders – The provincial contribution was inadequate for full implementation of the Information Line. A submission was made for HRDC funds and the project met the funding criteria. It was therefore able to go forward as intended.

Stay focussed on goals -- When many partners are involved in an initiative, the risk is greater that there will be competing priorities. It is important for the shared goals to be reconfirmed frequently in order to keep decision-making focused.

Be prepared for technological hurdles -- During the design phase, the partners explored the possibility of giving every worker access to the database. This proved not to be viable since the database could not be mounted on the shared network. The alternative would have been to put stand-alone versions of the database on each worker's computer but it would have been extremely difficult to keep the information current. Once technology issues are resolved, the situation will be reviewed.

History of Initiative

In 1999, the Social Services Committee of Dufferin County decided that the County should proceed with a proposal to become the deliverer for a co-ordinated information service under MSWFP. Following a community consultation, the MSWFP working group recommended that Dufferin County become the provider of co-ordinated information on services for children and for persons with developmental disabilities.

The CCAC agreed to let Dufferin County use a database developed by the CCAC to support an information line. The database included some information on Dufferin County. In return for the database, Dufferin made a one-time donation to the CCAC.

Since the County is small, the Social Services Department proposed that the information service incorporate all social services in the area rather than only those required by MSWFP. Council approved this proposal.

MSWFP funding was augmented with HRDC dollars. Funds covered the cost of implementation, including the services of a project manager.

The implementation process was planned in collaboration with a reference group of stakeholders and community partners – HRDC, Orangeville Public Library, Dufferin Volunteer Centre, Student and Youth Employment Services and Social Services. The group sets priorities for services to be included in the database.

For more information, contact Janis Grossett-Demorest at 519-941-6991 or by e-mail at: janisgd@dufferincounty.on.ca

DUFFERIN COUNTY AND DUFFERIN HOUSING AUTHORITY CROSS-TRAINING

Cross-Training in Governance and Administration

Synopsis

Goal: To strengthen the County's governance and administrative capacity with respect to Social Housing programs.

Approach: The Local Housing Authority's (LHA) board of directors conducts its meetings during meetings of the Dufferin County Standing Committee on Social Services and Long-Term Care. The LHA manager is being given experience in County administration.

Benefits: The County will have a stronger capacity to govern and administer the social housing programs, once they are devolved. The LHA manager, who has an in-depth understanding of social housing, will be in a position to compete effectively for a position on the County staff.

Purpose

For Dufferin County to become familiar with the roles and responsibilities associated with managing social housing programs in anticipation of becoming the service system manager for social housing.

Context

Following from Local Services Realignment, CMSMs now pay 100% of what had been the provincial share of social housing in their jurisdictions. Once the devolution of social housing is complete, CMSMS will become the service system managers for these programs. The cost of social housing in Dufferin County is higher than the County's costs for Ontario Works.

Currently in Dufferin County, the provincial Local Housing Authority (LHA) is the largest provider of social housing. The LHA conducts financial testing and maintains the waiting list for all providers of social housing, with the exception of Federal non-profit providers.

The LHA will be dissolved once the CMSM assumes responsibility for social housing. There is some concern that when this occurs, experienced LHA staff might leave the system, resulting in a loss to the County of their skills and knowledge.

Approach

The County and the LHA have undertaken cross-training between their organizations in governance and administration. This approach to training will give the County an opportunity to develop the capacity to effectively manage the social housing portfolio following devolution.

Governance

The Board of the LHA conducts its meetings in the context of the municipal governing structure. Under the chairmanship of a County administrator, the LHA board of directors holds its meeting during the larger meeting of the Dufferin County Standing Committee on Social Services and Long Term Care. The Administrator of the Department of Social Services for the County has chaired the LHA board of directors since September 1999.

In this way, councillors on the Standing Committee hear the deliberations of the LHA Board and are able to comment on the proceedings.

Administration

The County is:

- providing the LHA manager with experience in County administration which will enable her to compete for positions with the County following dissolution of the LHA, and
- developing protocols for dealing with the LHA employees.

Benefits

County staff are learning about the management and administration of social housing.

LHA staff will be in a position to compete effectively for positions with the County once devolution has taken place.

The LHA has had to change its monthly reports to meet the expectations of the County Council. As a result, the reports have become more focused.

Linkage between the Dufferin County Housing Program and the LHA

The County used part of the Provincial Homelessness Initiative Fund to hire a Housing Counsellor who provides support and referrals to residents in the County who are homeless or at risk of homelessness. The Housing Counsellor is available

one afternoon each week at the LHA office to accept new referrals and share information. This individual attends monthly housing access meetings that are held by housing providers.

Future Plans

The LHA will be co-locating with the County administration in order to further support sharing of expertise and skill development.

For further information, contact Carl Ross, 519-941-6991 or by e-mail at cross@dufferincounty.on.ca

7. Regional Municipality of Halton

HEALTHY COMMUNITY FUND

Partnership of Community Funders in the Regional Municipality of Halton

Synopsis

Purpose – To provide project funding for prevention-focused proposals that are submitted by community groups. Community groups submitting proposals are expected to have formed partnerships to address one of three community priority areas: healthy lifestyles, public/personal safety, or community services systems improvements.

Goal: To make Halton a "Healthy Community".

Approach – The Healthy Community Fund (HCF) is managed by a consortium of 12 funding partners, including the Regional Municipality of Halton, which is the lead administrative partner. The partners include community agencies and government bodies that have pooled financial, administrative and human resources for the purpose of making funds available to projects that meet HCF criteria. New partners to the HCF are welcome at any time. The partners are required to contribute a minimum of $1,000 per year. They are encouraged to commit, in principle, to a minimum 3-year involvement in the HCF. In 1999, the second year of the program, a total of $350,900 was awarded by the HCF for 24 projects involving more than 100 organizations.

Challenges – Some organizations have expressed interest in joining the HCF but are prevented from doing so because their funding mechanisms do not allow for funds to be "pooled" in a collective undertaking. As well, the time commitment for HCF funding partners was significant in the developmental stages.

Benefits – This approach leverages additional funds, helps to break down funding silos, promotes networking and builds community capacity.

Context

Regional Municipality of Halton CMSM

The municipalities of Burlington, Milton, Oakville and Halton Hills make up the Regional Municipality of Halton. Halton's current population is about 340,000, however it is projected to grow to more than half a million in the next 10 years.

Impetus

The impetus behind the Healthy Community Fund (HCF) was two-fold:

- The principles of a "healthy community" were adopted by the Regional Municipality in the context of the Official Plan. These principles include closer integration of land use planning and human services planning (e.g., land use documents are now circulated routinely to human services departments for comment), support for inter-sectoral partnerships, promotion of healthy public policies, and support for both increased voluntarism and community participation.
- A decision was made to phase-out Halton's Social Services Grants Program which provided core funding to individual social services agencies for a number of reasons, including:
  - funding had decreased over the years due to cut-backs,
  - the same agencies tended to receive funding each year making it difficult for new groups to access the program, and
  - it was felt that a different approach was needed to more effectively leverage financial and in-kind resources available within the community.

The HCF replaced the Social Services Grants Program.

Approach

What is the HCF?

The HCF is a product of a partnership of community funders, including the Region which is the lead administrative partner. The twelve partners have pooled certain financial, human and administrative resources for the purpose of funding projects in the community which meet HCF criteria identified below.

The HCF partners are required to contribute a minimum of $1,000 each year, as well as human and administrative resources (e.g., staff time, space for meetings, photocopying). In 1999, the initiative's second year, a total of $350,900 was awarded to 24 projects involving more than 100 organizations.

The vast majority of dollars that were allocated in previous years to the former Social Services Grants Program are now directed to the Healthy Community Fund. The Region is the largest funder, accounting for approximately 75% of the funds pooled. However, the Region has only one vote around the table and shares the ownership over policy and decision-making equally with the other partners.

The purpose of the Healthy Community Fund is to provide *project* funding to initiatives that will assist Halton achieve its healthy community goals. Although projects are typically funded for one year, some may be approved in principle for up to three years.

Funding Partners

At the present time, there are twelve partners in the HCF:

City of Burlington	Community Foundation of Oakville
Ministry of Community and Social Services	Town of Halton Hills
Town of Milton	Town of Oakville
Trillium Foundation	United Way of Burlington/ Hamilton-Wentworth
United Way of Milton	United Way of Oakville
Regional Municipality of Halton	Burlington Community Foundation

A Memorandum of Understanding, including Terms of Reference, sets out each organization's financial commitment, goals of the HCF, responsibilities of the funding partners, activities of the group, responsibilities of the lead administrative partner, and the HCF's expectations for funded projects.

Goals

The HCF is committed to working with the community to make Halton a "Healthy Community". The HCF views the way it operates, as well as the projects it funds, as role models for how organizations from different sectors can work in partnership to achieve common goals.

The goals of the HCF are to:

- act as a catalyst for organizations to work together to help Halton achieve its Healthy Community goals,
- encourage collaborative/partnership-based prevention approaches that address community, social and health priorities,

- increase broad-based public awareness of the determinants of a healthy community,
- build knowledge and expertise about methods for successfully bringing together resources from two or more sectors for the purpose of creating a healthy community,
- promote community priority-based funding in Halton Region, and
- achieve a balanced distribution of funding across all sectors.

Responsibilities of HCF Partners

The funding partners are expected to:

- establish funding priorities through an annual review of community needs,
- establish funding criteria, administrative processes, funding levels and resource requirements,
- review and approve funding for projects for 1, 2 or 3 year funding that, in the view of the group best meet the established priorities and criteria,
- endeavour to reach all decisions through a collaborative consensual decision-making process (each partner organization has 1 vote but may appoint up to 2 representatives),
- act as a resource to agencies that are developing proposals or requesting feedback on why a proposal was not funded, and
- evaluate the HCF model and review the evaluation of funded projects, following-up as appropriate.

Responsibilities of Lead Administrative Partner

The lead administrative partner is the funder that contributes the greatest amount of funding in the current year to the HCF. Each year to date, the lead administrative partner has been the Region. In addition to its responsibilities as a funding partner, the Region's responsibilities as lead administrative partner include:

- taking the lead role in implementing all decisions,
- assuming day-to-day management responsibility for the HCF,
- assigning staff to manage the HCF and participating as a resource,
- establishing a separate bank account through which all revenues and expenditures are flowed, and
- submitting all HCF allocation decisions to Regional Council for ratification.

Community Priority Areas

Community groups/organizations are encouraged to collaborate and submit joint prevention-focused proposals for funding under one of three community priority areas:

Healthy Lifestyles: Provides communities, neighbourhoods or families with the opportunity to improve healthy living practices. This support addresses areas such as child poverty, employment, and nutrition promotion.

Public/Personal Safety: Promotes community-based initiatives for increasing the public/personal safety and security of communities, neighbourhoods or families. Initiatives may address community priorities such as preventing substance abuse and elder abuse and promoting overall safety awareness.

Community Services Systems Improvements: Refers to improving service delivery in the community. This could be in the form of restructuring, as in co-operative ventures or joint service delivery solutions. It might also mean a full merger of existing agencies. Funding proposals may request assistance for administrative costs such as needs assessment and staff retraining. These improvements are expected to result in greater efficiency, effectiveness and viability of the current service delivery system.

In 1999, twelve of the projects funded have a child/youth focus, four deal with women or family-related issues, four address issues related to seniors or disabled persons, and the remaining four are directed at the general population. In 2000, the HCF will be reviewing updated research and community planning documents. Based on that review, the funding priority areas will be re-visited.

Proposal Criteria

Proposals must address how they meet the following seven criteria established by the HCF:

1. strengthen communities, neighbourhoods or families by addressing a demonstrated need,
2. involve collaborative partnerships between two or more groups,
3. increase community participation (e.g. as decision makers, advisors, participants in evaluation),
4. promote voluntarism/engage volunteers,
5. promote healthy public policies (e.g. support or address priorities raised in various local community planning documents),
6. outline how the initiative will sustain itself beyond the funding period, or has a limited time frame with lasting impact, and
7. identify indicators of the project's success against which the project can be evaluated.

The Healthy Community Fund also encourages projects that are:

- prevention-focused (i.e. that reduce the need for more intensive services at a later point),

- innovative in that they bring together two or more sectors as partners (e.g., volunteer student teachers from private dance schools provide instruction to children from low-income families in a local gym),
- partnerships involving the public, private and community sectors (e.g. business, environment, education, arts, health, social services, recreation, housing), and
- focused on involving or increasing the participation of people who are vulnerable or marginalized.

Proposal Review Process

Submissions are first reviewed by the HCF to ensure that the application is made under 1 of the 3 priority funding areas, eligibility requirements are met, and the requested application format has been followed. Submissions which meet these three conditions are then assessed by the HCF on the basis of the proposal criteria.

All HCF partners are actively engaged in evaluating the proposals. They are divided into teams to rate assigned groupings of proposals (e.g., proposals that target youth). A rating tool, as well as follow-up phone calls and site visits, if required, are all used in the decision-making process. In the second year, the full group met on three occasions to discuss the proposals, their evaluation, and the criteria and policies to ensure they were applied consistently.

Based on their review of proposals that were submitted in 1999, the HCF identified strengthening the collaborative nature of agency partnerships as an area for further development in 2000. Outreach efforts are being undertaken to arts, sports and environmental groups in an attempt to attract greater inter-sectoral participation in order to more closely reflect the healthy community concept.

Role of Regional Council

Each year, Regional Council approves an overall Healthy Community budget, the vast majority of which is allocated to the Healthy Community Fund. A small portion of the Healthy Community budget is allocated to a United Way partnership for small single agency grants and to the Social Planning Council.

Regional Council's role with respect to the allocation decisions made each year by the HCF is to ratify them. As the lead administrative partner for the HCF, this ratification of the HCF's allocation decisions by Halton Regional Council is a legal requirement to ensure accountability for the Fund.

Self-Evaluation

At the end of each funding cycle, the HCF undertakes both a process and outcome evaluation of its own work. The process evaluation focuses on how well the partners work together as a group while the outcome evaluation focuses on how the partners can improve outcomes (e.g., increasing funds available, receiving stronger proposals, increasing cross-sector collaboration).

The HCF developed a partnership evaluation tool to help them rate the extent to which they work collaboratively. This tool has also been made available to funded projects. With respect to outcomes, in 1999 MCSS joined the HCF and funds leveraged from non-Regional partners increased by $8,000. The partners hope to attract new members in 2000 and further increase the funds leveraged by all participating organizations.

Challenges

In the case of some organizations, their existing funding mechanisms and/or administrative practices restrict them from being able to pool funds in collective undertakings, some of which may be outside the scope of projects they would traditionally fund. For example, this is perceived to be a barrier for certain government ministries and departments joining the HCF (MCSS is the only provincial or federal government body to join the HCF to date).

The amount of time required of the HCF partners to fulfill their responsibilities is an issue that is being addressed. Similarly, it was noted that community organizations that are interested in accessing project funds need to ensure they build-in sufficient developmental time to secure an appropriate partner organization(s) with whom to develop a joint proposal.

The HCF needs to guard against prematurely evaluating other partnerships that submit joint proposals for funding against the high standard they have set for themselves. It needs to be recognized that partnerships take time to develop and nurture, and that partnering across different sectors presents its own unique challenges.

There is a need to ensure that the roles and responsibilities of Regional Council and the HCF are clearly demarcated.

Benefits

A variety of benefits have been realized by the HCF funding partners as well as the projects they fund, including:

- By pooling some financial, human and administrative resources, the funding partners are better able to leverage additional resources. In fact, an analysis of 1999 funded projects suggests that the ratio of HCF funding to the total value of other funding, in-kind contributions and volunteer hours is $1:$3.22.
- By encouraging inter-sectoral partnerships, more opportunities are created to eliminate program silos.
- The approach taken by the HCF to funding projects allows members to look beyond the types of projects they might fund on their own to think more holistically about what services people need. Projects that do not meet the

specific funding criteria of any one funding body may, given the broader mandate of the HCF, meet their requirements.

- The approach taken by the HCF to funding projects helps to build community capacity. By encouraging inter-sectoral partnerships and the involvement of a broad cross-section of the community, agencies have the opportunity to develop new areas of strength, forge new links with organizations, and take more ownership for the type of community in which they want to live.
- The Healthy Community Fund has heightened agencies' awareness of each other both within and across sectors and provided opportunities for agencies to partner with each other. With agencies in different sectors talking to one another, there is also a greater awareness of community needs. For example, an agency that provides services to autistic children partnered with the Parks and Recreation Department; the two developed a proposal for a Saturday swim program that was funded by the HCF.

Lessons Learned

- Partnering is time-consuming, in particular for those members of the funding group who commit time to project activities, such as developing funding criteria and administrative processes, reviewing and approving funding for projects, acting as a resource to community agencies, etc.
- Partnering requires nurturing at the community level. A truly collaborative partnership of agencies needs to be cultivated over time. To assist the community in developing partnerships, the HCF offered information sessions and provided information about example partnerships. The HCF is currently discussing co-ordinating a "partnership-building workshop" to assist agencies that are interested in partnering on a project.
- It is important to encourage flexible and creative approaches to funding/ administering a partnership.
- Large organizations in particular may need an internal champion whose role would be to break down barriers that prevent them from entering into partnerships.

Development of the Initiative

The Regional Municipality approached local funders including United Ways, community foundations, municipalities, the Trillium Foundation and various departments within the provincial and federal governments. In 1998, ten funders partnered to establish the Healthy Community Funders group. These 10 funders, and more recently the Ministry of Community and Social Services and the Burlington Community Foundation, make up the current funding group of 12.

The group developed a Memorandum of Understanding and Terms of Reference which articulates the goals of the program and the responsibilities of each partner.

The Region was appointed the Leader Administrative Partner and the HCF was co-chaired by two Regional Councillors for the first year. In the second year, the HCF was chaired by a United Way of Milton volunteer representative. Two municipal Recreation representatives from Milton and Oakville are co-chairing the HCF in 2000.

The HCF established funding priorities for the first three years (refer to Community Priority Areas). Eligibility and funding criteria were established and Guidelines distributed widely. In 1998, the first year of the HCF, 13 projects involving more than 70 partners received a total of $190,500. In 1999, 24 projects involving more than 100 partners received a total of $350,900.

For further information, contact Joan Kaczmarski at (905) 825-6000 or by e-mail at Kaczmarsj@region.halton.on.ca

8. Regional Municipality of Hamilton-Wentworth

INTEGRATED MANAGEMENT AND DELIVERY OF PUBLIC HEALTH AND SOCIAL SERVICES

Synopsis

Goal: To amalgamate two departments – Public Health and Social Services – into one. The objectives were to save money and to create a structure that supports integration of services.

Management Approach: The General Manager of the Social and Public Health Services Division and the Medical Officer of Health share responsibility for the management of those branches within the Division in which both public health and social services staff work.

Role of the Medical Officer of Health: The MOH has a dual reporting relationship – an administrative reporting relationship to the General Manager and a functional reporting relationship to the Board of Health on issues that concern public health.

Benefits/Losses: For clients, the new structure means less "shopping" for services. Staff from the two former departments are learning to work together to develop joint strategies for addressing the needs of their clients. Expertise and resources that used to be contained within one group are now shared. However, as a result of the merger of the two departments, middle management positions have been eliminated, resulting in some job losses and fewer opportunities for advancement. There is also concern about loss of professional identity.

Challenges: With the impending political municipal restructuring, staff are concerned that there may be further changes to the division at a time when they are still dealing with the realities of working in two merged cultures.

Municipal Context

The region of Hamilton-Wentworth includes the Regional Municipality of Hamilton-Wentworth and six area municipalities (Cities of Hamilton and Stoney Creek, Towns of Ancaster, Dundas and Flamborough, and Township of Glanbrook). The total population is about half a million.

Currently, the Region of Hamilton-Wentworth and the City of Hamilton are separate municipalities under the *Municipal Act*. In 1998, they voted to combine their administrative structures to create one unified administrative structure reporting to the two Councils. It was in the context of this administrative merger that the former Public Health and Social Services Departments, as well as the municipal non-profit housing unit, were amalgamated as a Social and Public Health Services Division.

This case study describes the new structure and the approach being taken to the management and delivery of public health and social services. However, the Provincial Government recently announced the creation of a single tier municipal structure for the Region to be called the City of Hamilton.

Impetus for the Organizational Restructuring

One of the driving forces behind the restructuring was to save money. In developing the new structure, which amalgamates public health and social services in one division, the goals were to:

- reduce the size of the bureaucracy,
- change what appeared to consumers to be a fragmented system to one that has functional groupings of complementary services,
- make a greater positive impact on social and health outcomes, and
- increase accountability for the services provided.

The administrative integration of the City of Hamilton and Region of Hamilton-Wentworth led to the development of a vision for organizing complementary programs and services in a way that made sense from a corporate and citizen perspective.

Mission, Vision and Values

The Social and Public Health Services Division's Management Team developed the following mission, vision and values for the Division (see Exhibit 1 on the next page).

Exhibit 1: Mission, Vision, Values

Mission

"To enhance the well-being of the citizen and community by ensuring the provision of mandated Social and Public Health Services."

Vision

"Our citizens believe that Social and Public Health Services offer good value and help make this community a great place to live."

VALUES

- Supportive work environment
- Community-oriented
- Collaborative
- Continuous improvement
- Innovation
- Integrity
- Treat people with dignity and respect
- Protect the public interest
- Excellence
- Dynamic learning organization
- Team work
- Communicative
- Customer focused

Divisional directors, charged with developing the vision, participated in a brainstorming session. The public health department had gone through the process of developing a mission and strategic plan before restructuring. When the new division was created, the senior management group built on this earlier work but also took the opportunity to re-think the division's purpose, and consider the gains and losses resulting from restructuring.

A formal orientation was planned for February 2000. During this event, all staff would re-visit the mission, vision and values to make sure that everyone is aware of them and interpreting them consistently across the division.

Administration

Organizational Structure

The Social and Public Health Services Division is managed by a General Manager. Within the Division, all Branches report to the General Manager for administrative purposes, some receive functional direction from the General Manager, others report

to the Medical Officer of Health for functional direction, and several have a functional relationship to both managers:

Four branches report to the Medical Officer of Health: Communicable Disease Control, Youth & Mental Health, Environmental, Dental Health, and Healthy Lifestyles & Disease Prevention.

The Employment & Income Support Branch, Finance & Administration Branch, and Macassa and Wentworth Administrators report to the General Manager for functional direction.

Three branches have a functional relationship to both the Medical Officer of Health and the General Manager: Community Support & Research, Parent & Child, and Housing & Shelter. Individual staff within these branches have administrative reporting relationships to one of the two managers, depending on which sector their positions are in.

Joint Management of the Division

The General Manager acts as the primary conduit to the Division's management team on general corporate issues. Divisional management team meetings are held with the General Manager, Medical Officer of Health and Branch Directors. This team makes decisions about the budget, service priorities and allocation of resources.

The Medical Officer of Health takes the lead role on matters related to the human and financial resources required for mandatory public health programs. With respect to discretionary public health programs, the Medical Officer of Health takes the lead role but the rest of the team has input to decisions. For social services issues, the General Manager takes the lead role and the Medical Officer of Health and other members of the team have input.

The General Manager and Medical Officer of Health each meet individually with the branches that report solely to them. Where branches report to both managers, the Medical Officer of Health covers public health issues and the General Manager does the same for social services. More frequent joint management team meetings across the two sectors will be scheduled to deal with specific issues.

The MOH's Dual Reporting Relationship

Typically, Medical Officers of Health report to Boards of Health. In Hamilton-Wentworth, the MOH has a dual reporting relationship. She reports administratively to the Division's General Manager and functionally to the Board of Health. It is a unique approach in the province. The General Manager believes it is sufficient to have a functional reporting relationship to the Board of Health in order to meet the requirements of the *Health Protection and Promotion Act.*

Service System Management

A significant factor behind the organization of the new Division was the intent to create a management structure that would support the creation of more integrated service systems. According to the General Manager, the aim of service system management is to bring together a variety of human services so that there are fewer silos at the local level where services are delivered. It involves:

- breaking down silos among programs and services,
- being creative in bringing together human services, and
- building relationships with local partners and stakeholders in the community.

In managing service systems, both managers feel it is important to consider the key determinants of health and the needs of the community. Managing service systems involves being mindful of the needs of the community, and how programs and services can be delivered so as to meet the community's needs.

As well, it is important to plan the development of service systems within their community contexts. Questions that must be addressed include: What is the optimal size and composition of the service system? What should the boundaries be for the service system to be effective? How big is too big?

Finance and Administration

The finance and administration functions of the two departments in the prior structure have been amalgamated. A single technology was adopted and further efficiencies may be explored. Before restructuring, the two departments had very different reporting formats. The introduction of a single technology has driven some alignment of the reporting formats.

A Platform for Service Integration

Service integration was already underway before restructuring. For example, all OW resource centres were integrated with HRDC resource centres – they were physically co-located, shared resources and had a common reception area. Devolution created additional opportunities for service integration. For example, OW participants were referred to child care staff for information on child care options. The new structure has opened the way for further integration:

- Child care staff are co-located with public health staff who are involved in delivering children's services.
- Drug, alcohol, and gambling services are being utilized by employment services. OW workers may make a direct referral to addiction services. The intent is to have treatment for these addictions become a recognized support to employment.

- The needs of youth, including decision-making skills and employment, are now addressed by public health nurses working together with Ontario Works staff.

Benefits/Losses of Restructuring

In the discussion of benefits and losses arising from the restructuring, it was noted that clients have easier access to services than was the case previously and there are more vehicles for communicating with clients, e.g., information about pre-natal nutrition has been included with OW cheques. However, since the case study addressed integration at a management rather than service delivery level, benefits and losses for the organization and for staff were the primary focus.

Benefits/Losses for Staff

Benefit – Broader Thinking

Staff are stimulated to think more creatively and broadly when they are exposed to different perspectives. For example, staff in the Healthy Lifestyles and Disease Prevention Branch are likely to think about the nutrition program from different perspectives rather than focusing on one aspect. Staff find it's easier to make these kinds of connections working with different groups of people.

Losses

Job Loss and Loss of Opportunity: The integration of public health and social services resulted in the reduction of some senior and middle management positions. With a downsized middle management layer, there are fewer opportunities for advancement.

Loss of Professional Identify: Some staff in both public health and social services are concerned about the loss of their professional identity and feel that their professional credentials and expertise may not be as valued by the organization.

Changes in Collegial Relationships: Staff are working with different people than before. They have had to leave teams and colleagues with whom they had worked and begin to develop new working relationships and teams.

Benefits for the Organization

Increased Collaboration: There are more joint initiatives and advisory committees (e.g. seniors, immigrants and refugees). Staff in different parts of the Division work together more frequently to develop joint strategies for addressing community needs. For example, Public Health nurses and staff in the Employment & Income Support Branch are developing complementary approaches for their respective activities in centres for youth and various other settings.

Improved Continuity: The General Manager and MOH are able to back-up each other. When the General Manager is away, the Medical Officer of Health is

responsible for the Division. When the Medical Officer of Health is unavailable, an Associate Medical Officer of Health (or qualified alternate) provides coverage on health issues and the General Manager is able to report on Public Health matters from an administrative standpoint.

Sharing of Resources and Expertise: There are more opportunities for staff to learn from each other and share resources. For example, the Community Support and Research Branch previously provided services to Public Health only. Now, their services are available to social services staff as well. (Exhibit 2).

Increased Efficiency: Prior to restructuring, public health and social services staff would often attend meetings with community groups and agencies. Now, in many instances only one person attends. As well, responses to the community are timelier and better co-ordinated.

Exhibit 2. Community Support and Research Branch

A significant benefit of restructuring has been the expansion of the research capacity on the social services side. Across the province, there are six teaching health units, including Hamilton-Wentworth, that have an in-house research and program evaluation capacity. Among these six, Hamilton-Wentworth is unique in terms of the level of its capability and in that both public health and social services staff are provided research and program evaluation support.

Within the Social and Public Health Services Division, the research and program evaluation function resides in the Community Support & Research Branch. This Branch has a functional relationship to both the General Manager and the Medical Officer of Health.

More than 50% of the Branch's resources are dedicated to provincial priorities. The balance of the resources are directed to meeting specific local requirements. Incoming proposals for research grants are reviewed against predetermined criteria and decisions are negotiated, based on priorities. An attempt is made to balance the interests of researchers with the needs and objectives of the corporation. This priority-setting process is undertaken each year in the context of budget and operational meetings.

The Director of the Community Support & Research Branch is compiling a description of "early wins" resulting from the Division's integration activities. An external consultant has also been hired by the Director to undertake a more comprehensive and objective review of what has been achieved through integration.

Accountability

With the assumption of responsibility for public health and social housing, in addition to social services, the General Manager is now accountable for the delivery of all these programs. At the present time, he reports to two Councils – Regional Council (which is also the Board of Health) and City Council. With the decision to devolve Social Housing, the General Manager now reports to Hamilton City Council on these issues.

Joint management has not affected the approach to performance measurement. Public health and social services programs continue to use the performance measures that were in place prior to restructuring. Performance indicators are reported in the context of the budget process.

The indicators vary depending on the program area. There are measures of the quality and efficiency of client services. Timeliness of service is viewed as a particularly important indicator of efficiency from a client perspective. For example, how long does it take to approve an OW application? how long are applicants for some services on waiting lists? Work is currently underway to develop new measures, where appropriate, and fine-tune existing ones.

Lessons Learned

The new structure is being implemented in an environment of considerable uncertainty as a result of consolidation which will take place at the political level. Further organizational change was not expected to take place so soon. It is not known if additional staffing changes might be made and how such changes would affect the division and individual positions.

The political restructuring has had the effect of putting some planned activities on hold. For example, there was a plan to physically re-locate some staff within the division to a more suitable space. The delay in re-locating staff is expected to continue to present a challenge to management and staff with respect to program integration. Nevertheless, in the course of implementing the new structure over the past year, significant lessons have been learned about implementing a management structure in which public health and social services are integrated.

Preparing for Integration

A necessary pre-condition for the successful integration of public health and social services is good relationships with stakeholders in the community. The pre-existing departments of Social Services and Public Health Services had a history of co-operative ventures with other departments and organizations upon which to build. For example, Public Health Services had good relationships with the District Health Council, McMaster University and the University of Guelph. In Social Services, OW offices were already co-located with HRDC. Good stakeholder relationships have helped pave the way to the further integration of a variety of programs and services.

Realigning the Organization

It was important to develop and gain staff commitment to a common vision, mission and values. The General Manager and the MOH found that they were successful in doing so in the following ways:

Develop a Common Vision and Mission: The brainstorming approach used to develop the vision and mission statements allowed participants to express their views in a process that gave them sufficient time to reach a satisfactory conclusion.

Gain Staff Commitment: It was understood that having statements describing the organization's vision, mission and values was insufficient. It was also necessary to gain staff commitment. A letter was sent to all staff describing the process that was used to develop the mission, vision and values. The vision, mission and values were communicated to all staff at branch meetings.

Integrating the Structure: Challenges and Strategies

The Challenge of Joint Management

The success of this integration model is dependent to a great extent on the relationship between the General Manager and MOH. Each has to be willing to share leadership and to let the other take the lead when it's appropriate to do so. They must agree to share leadership and responsibility, be flexible in their roles, and be willing to put in time to meet with each other. A related challenge is that each has to wear more than one hat.

Strategy: The General Manager and the MOH have been working together closely, meeting on a regular basis and yielding to each other's areas of expertise. In addition, they delineated their distinct roles and shared responsibilities, particularly with respect to the MOH's accountabilities to the Board of Health and to the General Manager. They continue to negotiate their roles over time and in response to emerging issues.

The Challenge of Managing Dual reporting Relationships

Having staff report to two different managers can be problematic. There is the potential for staff to "play managers off" against each other and for the two managers to give divergent directions. Within the matrix structure, branches that have a functional relationship to both the General Manager and Medical Officer of Health have had to adapt to the dual reporting relationships. Branch directors need to be clear about those areas within their branches that are distinctly public health or social services -- which issues should be reported to the Medical Officer of Health and which to the General Manager. They also need to know where there is overlap.

Strategies:

- Develop a common vision: The General Manager and Medical Officer of Health now have a common vision of how the matrix structure should work and they are communicating that vision to the Branch Directors.
- Be consistent with each other: The two managers must also deliver consistent messages. It is important for staff to see the General Manager and MOH as being "together" on issues and sharing a similar perspective. They have established processes that support a consistent approach, for example, they meet regularly and often.
- Support the new structure: Be seen as supporting the new approach. Convey the belief that this is the right way to go and that it can be successful.
- Communicate roles and responsibilities: Staff need to be well-informed as to their own reporting relationships, particularly where there is joint management.

The Challenge of Creating a Common Culture

With restructuring, staff from the former Public Health Department and Social Services Department have had to learn to co-exist. Bringing together public health and social services is challenging for staff in both sectors – it entails the merging of different philosophies and organizational cultures. A complicating factor has been that public health staff felt that the province's vision regarding the role of public health in CMSMs was not clearly communicated. There is also a perceived lack of clarity regarding how hospitals, long-term care and other health-related components fit with the CMSM model, or how public health fits with the new regional model of the Ministry of Health and Long-Term Care.

Strategies:

- Managers must "walk the talk": Both the General Manager and Medical Officer of Health believe it is critical for the two of them to have a common approach and philosophy and have worked at developing these.

- Find ways of encouraging support for the new common culture (make it fun): A variety of things have been done to help staff accept that they're part of a joint division. For example, (1) a divisional open house was planned for February 2000 and (2) the General Manager and Medical Officer of Health jointly attend branch meetings. On a less serious note, pens and bookmarks inscribed with the Division's name have been provided to staff as prizes for answering the phone with the correct name of the branch.

The Challenge of Developing Common Terminology

Social services and public heath staff have come to realize that each group has a different interpretation of such commonly used terms such as "provide" and "deliver".

Strategy: It is important for each group to understand what the other means by these terms. Consequently, joint meetings to explore the meanings of such terms from social services and public health perspectives have been set. It is not the intent to agree on a single definition but rather for the two groups to understand each other.

Applicability of an Integrated Management Model

The view of the General Manager and Medical Officer of Health is that the Hamilton-Wentworth model might be difficult to implement in a larger community. Their rationale is that, for this model to work well, it needs to work effectively at the front-line staff level. It is important for front-line staff to know their counterparts in other program areas, to know how they work and what services they offer, and they need to be able to get in touch with each other easily. Given the size of bureaucracies in larger communities, this level of staff interaction and knowledge across programs would be very difficult to achieve and costly to implement.

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9. Regional Municipality of Ottawa-Carleton

INTEGRATED EMPLOYMENT SUPPORT

RMOC-HRDC Partnership

Synopsis

Approach – The Regional Municipality of Ottawa-Carleton (RMOC) and HRDC entered into a partnership to establish an integrated employment resource centre (ERC) that serves three groups: OW participants, EI clients and EI reachback clients, and the general public. The centre is located in a mall, and is staffed by RMOC employees. Services provided include specific employment supports, such as resumé writing and job preparation workshops as well as self-directed services such as access to job banks, photocopying and word processing.

Clients – A generic service approach is used in the ERC. All clients receive a "smart card" which is scanned at each visit to the ERC. This card contains information on the type of client and the services used. Provisions have been made to meet the needs of "hard to serve" clients through community outreach workers.

Community Partners – Community employment agencies use the facilities of the ERC free of charge. These agencies provide a range of supplementary employment services on the premises.

Benefits – Clients using the ERC can access a comprehensive range of employment services at one location. Having a mix of client groups promotes egalitarian treatment by staff. Community partners have access to a large pool of potential clients. The Regional Municipality and HRDC are better able to meet their respective objectives.

The Vision

"To provide the best employment services in a single, accessible location for all persons requiring these services."

This vision is supported by both partners – the Regional Municipality and HRDC – as well as community agencies.

Target Groups

The Employment Resource Centre (ERC) serves three groups: EI recipients and reachback clients[3], OW participants, and members of the general public, who comprise one third of the clients who use the ERC.

Services

About 15 RMOC employment workers are employed in the ERC to assist people with their employment-related needs. Services provided may include:

- Self-directed services such as access to the internet for job search, photocopying, computers for word-processing, and the federal job bank, are available to all clients of the ERC at no charge.
- Specific employment support services such as resumé writing, job preparation, and skills and training workshops are also available. For OW participants these workshops are provided in-house by RMOC employment support staff. ERC staff refer EI reachback clients and EI recipients to community agencies which offer workshops, either at the ERC or in the community. For example, Job Connect runs an apprenticeship workshop every month at the centre.

ERC services are client-centered, designed to answer the question "What do you need from us?" To support this, an inclusive, non-discriminatory approach has been adopted:

- The centre offers employment services to anyone looking for work.
- Workers are not aware of the clients' income source – i.e., whether or not they are social assistance recipients. A single set of rules for using self-directed services apply to all client groups. As a result, all clients are treated in a uniform manner.
- Workers are not assigned to a specific individual or client group (i.e. income source). Clients see the worker on duty. If so desired, however, clients can arrange follow-up appointments with specific counsellors.
- Clients do not need to book appointments, staff are always available to help them.

The ERC does not monitor the use of services, rather it operates on a trust system. Giving clients responsibility for managing *their own* use of services eliminates the need for monitoring and also promotes positive self-esteem and self-confidence, characteristics which are important for any job searcher. It also frees staff from policing responsibilities, allowing them to take on more of a helping role.

As a result of the growing popularity of the centre for job seekers and the lack of red-tape faced by employers, employers have begun to post jobs in the centre.

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[3] Clients who have received EI or were eligible to receive EI within the last 3 years, or parental benefits within the past 5 years.

Some clients are served through outreach services because they are limited in their ability to make use of services in a self-directed way or are reluctant to use a centre with a generic approach to services. The people in this group may have been out of the labour market for extended periods of time and as a result have become fearful of technology or intimidated by the other job seekers. Others may have difficulty coping with their personal circumstances. Outreach workers located in community centres provide employment counselling to individuals who need special attention or support. They are also able to link these people with other community resources.

Community-Based Partners

Ten community agencies with expertise in specific areas, such as employment support for youth, conduct information sessions and deliver services in ERC space at no charge to them. RMOC advertises these activities on behalf of the agencies.

The partnership among the community-based agencies is based on a common vision – "best service for the client" – and a shared belief that one agency cannot meet all clients' needs. By bringing these agencies and their clients together (e.g., youth, persons with disabilities, ethnic and linguistic groups), a comprehensive range of employment services can be co-ordinated and delivered.

The agencies have worked together to design and implement registration and referral procedures among themselves, to iron out "territorial" issues, and to determine where their commonalities and differences lie. This has resulted in streamlined registration and referral processes among the partners as well as improved referrals into the community.

Besides being able to use the ERC facilities and space at no charge, the agencies have access to a larger pool of clients. The experience of Algonquin College illustrates the benefits to these agencies. Prior to the partnership with the ERC, Algonquin had difficulty filling seats in their Non Traditional Jobs for Women course. Now that they advertise and hold their orientation sessions at the ERC, the program is fully subscribed.

Client Information and Technology

A "smart card" is used to feed information on the use of services, e.g., internet, workshops, equipment, etc., into a common client database developed to capture information about use of services and resources at the ERC. The only identifier on the card is the bar code. Clients who use the ERC swipe the card through an electronic reader at each visit or referral. This action automatically updates a client database.

The database identifies individuals as OW participants, EI recipients or members of the general public and contains tombstone data, client type, date of every visit and type of service accessed. This makes it possible for separate reports to be created for

each partner. OW case managers receive regular updates on the use of service by their clients. HRDC receives a list of EI clients, identified through their Social Insurance Numbers, along with information about the number of visits and courses attended. Both HRDC and the OW case manager use this information to monitor follow-up to employment plans.

At the time this report was written, RMOC had not yet implemented Ontario Works Technology (OWT). It is expected that OWT will link with the ERC's card system to provide the service delivery indicators required for the OW program.

Benefits of an Integrated Approach

Benefits to Participants and Clients

Having a generic pool of clients using the same services promotes informal networking among a variety of people from different backgrounds and work experiences. Clients with a strong attachment to the labour force, as well as those struggling to gain a foothold, benefit from networking.

Historically, expectations of social assistance recipients have been lower than those of the general public. The generic approach to service provision at this ERC has reduced bias in the treatment of individuals. A respectful environment has promoted client self-direction and self-confidence, essential elements for successful job search and job maintenance.

The partnerships enhance each group's knowledge of the internal and external services available. As a result, appropriate referrals are made more often.

Having workers available on a first-come-first-serve basis, without the need for appointments, is particularly helpful when clients need assistance in a short time frame, e.g., preparing for an upcoming interview.

As a result of mutual support that clients receive from their peers in the centre, staff members are able to spend additional time with those who require more assistance.

Other benefits include:

convenient and easy access to a range of services: one stop shopping, located in a mall on a bus route,

- free use of essential job searching tools, e.g., fax, photocopier, computer, job bank, internet, and
- reduced dependency on a particular employment counsellor.

Benefits to Staff

The non-stigmatizing environment has minimized the likelihood of angry responses from clients, thereby reducing concerns about violence.

Clients monitor each other's use of self-directed services and bring abuses to the attention of the staff, removing the onus from staff to be constantly vigilant over clients. As a result, staff are able to work with a variety of clients and deal with many issues which are challenging and rewarding.

Benefits to the Community-Based Partners

Community agencies, especially those with small budgets are able to advertise their programs to hundreds of potential clients, and use rooms for workshops and orientations free of charge. As a result of their presence in the ERC and their relationship with RMOC, there are more opportunities for clients to choose the services of these agencies.

Benefits to Employers

Although the ERC is not actively marketed to employers, they are posting jobs at the Centre. This is likely because:

- the free job posting service enables them to reach approximately 200 job searchers per day, and
- there is minimal "red tape" – employers do not have to meet numerous criteria in order to post jobs.

Benefits to the Organizations

The provision of specialized one-on-one employment counselling has been minimized with the advent of Job Link and OW. This has resulted in a much larger number of clients receiving services. The client to counsellor ratio was 60:1 under the one-on-one counselling model. Now, 4,000 clients are served in the centre each month.

By serving the general public, the centre may prevent some unemployment. Workers who have been given layoff notices are able to visit the centre and access the services they need before they are laid off and applying for EI or OW.

Partnership Responsibilities

Each partner has contributed significantly to the success of the project.

HRDC has provided:

- funding to double the number of computers in the ERC at a cost of $50,000,
- $250,000 to renovate the space, and
- funding for 5 additional staff positions.

RMOC has provided:

- management staff who are responsible for all staffing and operational delivery of services,
- funding for additional leasing costs for 5 years related to the additional space, totaling $50,000, and
- funding for 10 OW employment staff.

Support at the Political Level

The project has had political support at the federal and municipal levels from its inception. The Minister of HRDC and the Regional Chair presided over the opening of the ERC which was attended by MPPs and MPs.

Regional Council approved $50,000 over 5 years for the additional leasing costs.

Dealing with Overlapping Accountabilities

Service data are maintained in the client database for each user of services. Reports specific to each partner are generated on a regular basis. The OW case worker receives follow up reports which are used to monitor compliance with Participation Agreements. Similarly, HRDC receives reports on the use of services by EI recipients.

Linkage with Income Maintenance

RMOC's overall strategic direction is to foster greater integration between the financial assistance and employment assistance components of OW. There is now a single Director for Income and Employment. RMOC is timing leases to allow for formal co-locations of income maintenance and employment staff. Cooperative initiatives among income maintenance, employment services and community agencies are encouraged.

At this particular site, income maintenance workers are invited to hold their team meetings and training sessions at the ERC. RMOC is negotiating with the landlord to bring an Income Maintenance office into the same mall that houses the ERC. It would be located a few doors away as the ERC space cannot accommodate both offices.

Lessons Learned

Successful Implementation Practices

Shared Vision

Establishing and gaining commitment to a shared vision is critical. The bureaucratic requirements of two different organizations, let alone two different levels of government, made it challenging at times to implement and maintain the vision.

Written feedback from clients was solicited by staff and through feedback forms located throughout the ERC. The feedback, which has been positive for the most part, was fed back to managers and staff, helping to maintain commitment to the vision.

Management Support

As there was commitment at the senior level, issues that could not be resolved at a lower level were elevated to, and quickly resolved at a higher level.

RMOC employment counsellors had been providing services to 7 clients per day under the previous service model. Expectations were set of workers to see substantially more clients each day. Management did not try to "do more with less". Additional resources were obtained from HRDC, new technology implemented, more staff hired, and procedures established to support these dramatic changes.

Client-Centered Approach

A "client-centred" approach shifted the focus from organizational or "systems-centred" issues to delivery issues.

OW participants and EI recipients were involved in the planning process as well as in the ongoing shaping of services:

- Through focus groups, OW participants indicated their support for a generic model – they wanted a centre that was open to all, with no stigma associated with participation in OW. They also wanted the level of service to be maintained.
- Client input helped to ensure that services that people need are developed. For example, the number of internet sites was increased in response to feedback from clients.

Communication

- There was a concerted effort to maintain a flow of good information between staff and management, including progress on the integration initiative.
- Providing regular feedback to staff and management through monthly reports helped to ensure that staff felt their concerns were being addressed.

COLLABORATION

Integration proved to be more successful than co-location. A previous attempt by RMOC and HRDC to co-locate, with each organization maintaining its own staff and managers, was unsuccessful. The current initiative involves a higher degree of service integration and collaboration between the two organizations and the results are extremely positive.

Potential management issues related to staff from two different government organizations working together were circumvented through agreement that RMOC would manage the ERC staff.

FLEXIBILITY

Both parties committed to being flexible in meeting emerging service needs:

- The terms of contractual agreements were changed as needed, for example, serving the general public was not built into the original contract.
- Resources were added to improve services and to meet the needs of the new client group without reducing services to the OW participants and EI clients.

Changing the Organizational Culture

- RMOC undertook a range of activities designed to prepare OW staff for the change and to foster a common language over a 6-month period:
  - Formal: teams were given specific topics to discuss, e.g., partnership, best ways to serve clients.
  - Informal: the coming changes were topics for discussion during staff meetings.
  - Small working groups were struck to address specific issues.
  - Service principles were developed during a 1.5 day meeting that included all the teams.
- Management communicated a consistent message to staff in a variety of ways, e.g., through newsletters, at staff meetings, by participating in team activities and communicating their support for the initiative.
- By reducing the need for staff to monitor resource usage by clients, they had more time to perform the more rewarding parts of the jobs – assisting clients. This generated support for the generic, non-stigmatizing approach.
- Staff planning sessions were held to address such questions as: how do we want to serve clients? what do we mean by client? what will the shift to a broad client group mean?

- Employment staff who worked with OW participants typically assumed a monitoring/policing role. They had to make a shift to:
  - dealing with a broader group of clients and their issues, and
  - supporting clients using services at their own discretion, without imposed limits.

  This shift was achieved, in part, through a focus on service provision rather than clients – the type of services the centre would provide and the way they would be provided.

History of the Initiative

Without specific plans to co-locate, HRDC and OW had rented space in offices adjacent to each other in the same mall for their employment resource centres. The two offices offered many of the same services to clients, many of whom accessed both offices.

A number of factors led to the initiation of discussions about co-location and integration of service delivery in a single employment resource centre:

- There were complaints from the public about the apparent duplication of services and inefficiencies of this arrangement.
- At about the same time that the integration initiative was being developed, HRDC had begun a restructuring process which would result in the contracting out of many of the functions performed by HRDC staff up until that time.
- HRDC was already funding OW to provide employment services to EI reachback clients.

Integration was seen as a cost-effective solution since the resources contributed by HRDC could be used to augment an existing program infrastructure, whereas, by itself, the HRDC financial commitment would be insufficient to create a new centre.

HRDC contracted with RMOC to deliver all employment services to EI recipients and reachback clients. Staff and managers from each partner organization worked together to plan for the integration. This initiative had the support of management in both levels of government. As well, a mechanism was developed for issues that were unresolved at one level to be taken to the next for prompt resolution.

Originally, the ERC served only EI recipients and OW participants. People who were ***not*** EI recipients or OW participants began to seek services at the ERC. In response to the increased demand for services, RMOC requested resources from HRDC to enable them to provide more services and to conduct a study of the non-EI/OW group seeking services. RMOC found that this was a heterogeneous group, including, for example, people living with working spouses, people with savings, people who were underemployed, and those who wanted career changes.

The partners (RMOC and HRDC) believed that serving this additional group would be a means of helping some individuals ***at risk*** of needing financial assistance to

become employed or to enhance their employment situation. It was therefore decided to make the services offered at this ERC available to the general public as well, at no charge.

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10. York Region

York Region comprises nine area municipalities covering 1,756 square kilometres (768 square miles), stretching from Steeles Avenue in the south to Lake Simcoe and the Holland Marsh in the north. The nine municipalities are Aurora, East Gwillimbury, Georgina, King, Markham, Newmarket, Richmond Hill, Vaughan, and Whitchurch-Stouffville.

The current population of 694,000 is projected to reach 1,196,000 in 2021. The continued success of the Region is contingent on how well the Region manages this period of growth.

The delivery and timing of services to the residents of York Region requires the co-ordination of a broad spectrum of agencies and organizations including: the Region, local municipalities, school boards, human service providers, environmental agencies, utilities, emergency services, transit operators, provincial and federal governments and ministries.

Planning human services for the residents of York Region is a key component of the Region's growth management strategy and the Regional Official Plan. Human services are defined as the programs, facilities and services that support a safe, healthy community and maintain and promote its quality of life. York Region has approximately 1,000 providers of human services ranging from large organizations such as school boards and hospitals, to smaller volunteer or faith-based organizations, such as churches, support groups and neighbourhood centres. Non-profit and commercial organizations and individual practitioners also provide human services.

In 1999-2000 the Region undertook the development of a Human Services Strategy, defined as a long-range plan for co-ordinating the human services required to support York Region's vision. The plan is being designed to ensure that human services are in place throughout York Region when and where they are needed over the next 25 years. Human Resources Development Canada is partnering with York Region in the development of the Strategy by providing funding and leadership.

The Human Services Strategy Steering Committee has representation from York Region, Human Resources Development Canada, Area Municipalities, York Region District School Board, York Region Catholic District School Board, Seneca College of Applied Arts and Technology, York Regional Police, York County Hospital, Markham-Stouffville Hospital, York Central Hospital, Simcoe-York District Health Council, York Region Community Care Access Centre, Ministry of Health and Long Term Care, Ministry of Community and Social Services, and United Way of York Region.

Community Services and Housing Department

The Community Services and Housing Department (formerly called the Social Services Department) was restructured in 1999 in order to better address the additional responsibilities conferred on the Region as a result of Local Services Realignment. This reorganization was designed to establish a management structure that would support an integrated approach to the management and delivery of human services, both internal and external to the Region. Under the reorganization, a Commissioner of Community Services and Housing is responsible for 3 program divisions (Family and Children's Services, Social

Assistance, and Housing and Residential Services) and 2 support divisions (Business Services and Policy and Community Development).

Health Services Department

The Health Services Department has also been restructured, partly to respond to the changes resulting from LSR. Health Services consists of 3 divisions (Emergency Medical Services, Long Term Care and Public Health) and an administrative support division that includes financial administration and policy development.

Integration Activities

Cross-departmental functional integration is fostered through the activities of a Multi-Year Corporate Plan. The Human Services Cross-Departmental Team, with representation from all Regional departments (i.e., Community Services and Housing, Health Services, Planning, Transportation & Works, CAO's Office) meets bi-weeky.

The Region has had an integrated approach to the delivery of services to families with special needs or high risk children since 1994 (Early Intervention Services). A number of integrated approaches to service delivery have been implemented more recently or are in the process of being implemented. Some of these are:

- single point of access for children's services,
- joint municipal/HRDC ventures, such as a conference for OW Sole Support Parents, establishing Employment Resource Centres in community centres, identification of EI reachback clients,
- development of OW case manager positions, and
- integration of Ontario Works and Child Care, linking in NCB reinvestment.

As well, an integrated centralized intake screening unit for all programs in the Community Services and Housing Department is planned.

Two integration initiatives were included in the case study:

1. Early Intervention Services
2. Integration of Ontario Works and Child Care.

INTEGRATED SERVICES FOR CHILDREN: "EARLY INTERVENTION SERVICES"

York Region and Markham-Stouffville Hospital

Synopsis

Integrated Services for Children with Special Needs — York Region and Markham-Stouffville Hospital entered into a partnership to integrate programs that are funded and managed through the Ministry of Community and Social Services and the Ministry of Health and Long-Term Care. These programs are Infant Development, Child Care Special Needs Resourcing, and Preschool Speech and Language. Interdisciplinary teams plan and deliver a range of services to children with special needs and high risk children: assessment, service planning, child and family intervention using a mediator model, home visiting, and referral. The teams bring together staff with various professional backgrounds and expertise.

Partnership – Through an agreement with the Markham-Stouffville Hospital, Speech and Language Pathologists hired by the hospital participate in the interdisciplinary teams. As well, Preschool Speech and Language services are co-located with EIS in its delivery sites. Preschool children identified as needing a speech and language assessment are referred to the Preschool Speech and Language Program through EIS.

Central Access for Clients — These programs are accessed through a centralized intake number.The intake worker determines whether the family should be directed to EIS and/or Preschool Speech and Language. Child Care Financial Assistance and Child Care Information Services are also accessed through the central intake.

Linkages — Close co-ordination and cross-training is occurring with Healthy Babies Healthy Children and policies are being developed to facilitate the relationship between the two programs. EIS provides support to children with special needs entering the school system as well as to the Board of Education staff who will be working with these children. Linkages with other children's service systems include: professional mentoring to Learning, Earning, and Parenting (LEAP) caseworkers; program support and joint planning with Family Resource Centres; service protocols are in place with two children's mental health agencies.

Benefits of Integration — The primary benefit is a system of seamless services for families with children who have special needs or who are at high risk. As well, staff benefit from the cross-training opportunities and the team approach.

Mission

"Early Intervention Services provides information, education, and support to families and their infants and young children with special needs in York Region. Children are served within the context of their family and community. We work in partnership with families and service providers with the aim of enhancing and reinforcing supports."

Target Group

Early Intervention Services (EIS) targets families with children up to age six who have special needs or who are at risk for poor outcomes as a result of delayed development, specific conditions, injury or health factors, or environmental/social factors.

The Service Delivery Model for Early Intervention

A range of early intervention services is provided by an interdisciplinary team funded under three program streams:

- Infant Development (Ministry of Community and Social Services, *Child and Family Services Act*)
- Child Care Special Needs Resourcing (Ministry of Community and Social Services, *Day Nurseries Act*)
- Preschool Speech and Language (Ministry of Health and Long-Term Care).

Through co-location, joint planning, and joint service delivery, clients of these programs are able to access a seamless set of services.

Services under Infant Development are provided to children up to two years of age; services under Child Care Special Needs Resourcing are provided for children over the age of two. Preschool Speech and Language Program services are funded for children under 5 years of age. By using the funding streams to develop and support a single team that delivers services, families do not need to transfer to a new organization or service provider when the child reaches two years of age.

Services include:

- team assessments,
- service planning,
- group interventions,
- home visiting, as needed, to develop and/or reinforce individualized family support plans,
- case conferences, and
- informal discussions, as needed.

A team that includes early interventionists, physiotherapists and occupational therapists, speech and language pathologists, and communicative disorder assistants, assesses the child and family. The early interventionists come from a variety of backgrounds — psychology, special education, nursing, early childhood education — and some hold Master's degrees. Families are active participants in the assessment as well.

Following the assessment, an Individualized Family Service Plan is written. The Plan clearly delineates the roles of each agency/professional and is shared with each provider involved. Periodic team meetings are held to review progress and there is regular telephone contact among those involved with a family.

A mediator model is used to deliver services that are designed to help parents:

- understand their children's growth and development through screening and assessment,
- teach their children new skills,
- access community programs and resources, and
- reach goals that are important to the well-being of the family and child.

Some of the services are delivered through parent-child intervention groups, parent support groups, and education workshops. There is also a home visiting component in EIS. The early interventionists provide family support through home visits; if needed, the early interventionists conduct home visits together with the speech pathologists when both services are involved with the same child. Similarly, when HBHC home visitors are involved with a family, home visiting is planned jointly. Referrals are made to the specialized services, when appropriate.

York Region Partnerships and Linkages

York Region, through its Community Services and Housing Department[4], Family and Children's Services Division, manages and/or delivers programs for children: Child Care Fee Assistance, Child Care Support, Infant Development and Child Care Special Needs Resourcing. The Markham-Stouffville Hospital is a delivery site for the Preschool Speech and Language Program. The two organizations entered into a partnership to create a system of services for children with special needs. Over time, the partnership has developed linkages with:

- family resource centres,
- Healthy Babies Healthy Children,
- boards of education,
- the Child Care Enhancement Fund, and
- the Early Years Demonstration Project.

[4] Formerly the Social Services Department

Partnership with Markham-Stouffville Hospital

Integration is achieved at both the service delivery and administrative levels through a legal agreement between York Region and the Markham-Stouffville Hospital.

Speech and Language Pathologists and Communicative Disorder Assistants from the Hospital and the early interventionists, occupational and physiotherapists from the Region work together in the interdisciplinary teams and other joint activities to create a seamless set of services. These joint activities also are mechanisms for facilitating cross-training of staff.

The Preschool Speech and Language Program is co-located with EIS teams in each of the four EIS offices. A common screening tool is used to identify children in need of early intervention and speech and language services, although each service uses additional assessment instruments, as necessary.

Written protocols have been developed regarding performance management, team meetings, and team assessments, e.g., the role that the supervisors of the EIS Program have in the performance appraisal of the Speech Pathologist, identification of cross-training needs, etc.

The two organizations have an agreement to share some of the costs of co-location and some administration costs. As well, York Region, in its role as Child Care Service System Manager, funds a small portion of the Preschool Speech and Language Program, the major portion being funded by the Ministry of Health and Long Term Care. The Region invoices the Preschool Speech and Language Program for some of the administrative services it provides and a portion of the shared intake worker's pay. The Region does not invoice Markham-Stouffville Hospital for rental of the space. This enables more funding to be spent on direct speech and language services to families.

Linkage with Central Intake for Children's Services

A central intake number accesses the four programs that serve young children and their families. By calling this "Kids' Line" (703-KIDS), families are able to access:

- EIS,
- Pre-school Speech-Language Program,
- Child Care Fee Assistance, and
- Child Care Information.

Callers select the service they want to contact. A designated intake worker takes calls for EIS and Preschool Speech and Language. This person is trained and qualified to conduct a detailed screening over the telephone and to answer questions about aspects of a child's developmental status. The worker determines whether the family should be directed to EIS, PSLP, to both programs or to another service in the community, e.g. a children's mental health service. If the child requires the services of both EIS and PSLP, no further calls by the parents are needed, as the single call accesses both programs.

Eligible staff will be rotated through the EIS/PSLP intake worker position in order to develop a pool of trained workers and to support staff development.

Linkage with Preschool Speech and Language

PSLP services include public awareness and prevention, parent education, screening, assessment and treatment, and transition planning. These services are provided by speech-language pathologists and communicative disorder assistants.

Families with children to age 4 years 11 months who are eligible for direct speech and language services as a result of speech or language delays are able to access the services they need through the centralized intake (Kids Line). Intensive, direct speech and language services are usually provided in 10-week blocks.

Preschool-age children identified in the EIS as requiring direct speech or language services are referred to the PSLP. Some preschool-age children referred to the Preschool Speech and Language Program require direct therapy. Where less intensive services are needed, parents receive consultation and education that is equivalent to the EIS mediator model, but is delivered primarily by the speech-language pathologists.

Linkages with Child Care

Informal case referral and co-ordination occurs among the four programs. This is particularly evident where EIS and Preschool Speech and Language are co-located with, or in close proximity to, Child Care Services and Child Care Fee Assistance staff.

In order to facilitate formal referrals between EIS/PSLP and Child Care Fee Assistance, an interface between the Child Care Management System database and the EIS/PSLP database will be implemented in 2000.

Linkages with Healthy Babies Healthy Children

Some of the EIS families are also served under York Region Health Services' Healthy Babies Healthy Children. This sometimes results in home visiting from both programs -- professional home visitors from EIS and lay home visitors from HBHC. When this occurs, the EIS home visitor consults to the lay home visitor, whose role is primarily to provide non-professional support to the parents, e.g., accompanying parents to a Family Resource Centre or helping them learn how to use public transit . The EIS home visitor is responsible for monitoring the child to ensure that the child does not fall behind developmentally, and to provide professional support to the family in areas impacted by the special need of the child, e.g. linking the parent with other funding supports such as Special Services at Home or the Assistive Devices Program. The two home visitors jointly plan home visiting for the family and the EIS home visitor may schedule home visits to coincide with those of the lay home visitor. This provides an opportunity for the lay home visitor to become more informed about the family's specific issues and needs.

HBHC lay home visitors and Public Health Nurse mentors may be included in the initial EIS interdisciplinary planning process if they are involved with the family at that time. If HBHC involvement begins after the initial interdisciplinary planning process HBHC staff will be included in subsequent team meetings and planning activities.

A protocol for working together and making referrals between the programs has been developed. HBHC public health nurses refer families to EIS if child development issues are noted.

Currently the policy is being revised to accommodate the expanding mandate of Healthy Babies Healthy Children. Further joint policy work will result in clearer criteria to determine the circumstances in which EIS home visitors need to be involved and the level of their involvement, when lay home visitors are working with a family.

There has been collaboration between the programs on specific initiatives. For example, they participate in jointly-developed screening clinics operating in 13 Family Resource Centres. Staff from EIS, PSLP, Healthy Babies Healthy Children, and Blue Hills (a children's mental health agency) conduct clinics on advertised screening days, to which parents can bring their children without appointments. Of the children brought to the clinic and found to have identified needs, approximately 90% have a single need, the remaining 10% evidencing multiple needs. Referrals of children with identified needs to either EIS or Preschool Speech and Language Program are processed at the clinics, saving the parents a referral call.

Program staff from Early Intervention Services and Healthy Babies Healthy Children are being cross-trained:

- The staff of each have opportunities to participate in some of the other's workshops, e.g., child abuse recognition and reporting.
- EIS staff have conducted training for Healthy Babies Healthy Children family visitors. Public health nurses have conducted training for EIS staff on family assessment.
- The EIS manager has consulted to the Healthy Babies Healthy Children program on several initiatives, e.g., the Lay Home Visitor Training Manual, Post-natal Visit Training and the manual, and the Healthy Babies Healthy Children Professional Home Visitor Training Manual.

Linkages with School Boards

Linkages with local school boards support the entry of children with special needs into the school system and provide the boards with information they need in order to obtain special needs funding:

- School boards are notified a year in advance of the number of special needs children who will be entering the school system.
- EIS staff are members of each District School Board's Special Education Advisory Committee.

- EIS and the two District School Boards have revised existing transition processes to better meet the needs of the schools boards:
  - EIS provides case documentation to the schools.
  - EIS shares the functional assessment tool (the Hawaii Early Learning Profile) it uses with the Boards for children entering junior or senior kindergarten. EIS provides training for school personnel on this tool's use to ensure continuity for the child and family.
  - Staff provide consultation to the classroom teachers for several months in order to achieve continuity between the Individual Service Plan used in the child care centre and strategies used in the classroom.

Linkages with the Enhancement Fund

York Region EIS and Child Care Services administer funds on behalf of a community committee, the Child Care Enhancement Committee, which makes recommendations to the Region regarding the levels of supports for children with exceptional special needs integrating into child care settings.

The funds are used to support children who require more than the usual supports to successfully make the transition into inclusive environments, e.g., children with Autism/Pervasive Developmental Disorder, behavioural disorders, significant attention or impulse disorders, etc. The employment of the parents of these children is considered to be at risk if the child care centres cannot successfully integrate these children into the centre.

The enhancement funds are designed primarily to offer short-term support to the centres for the inclusion of children with exceptional special needs. This support is coupled with a planned withdrawal of the support as the child adapts to the centre's environment, and the centre's staff become better able to manage the child's behaviours. The Region's integrated services approach has reduced the amount of funding that is needed for administration and allowed a greater proportion of the enhancement funds to be used for direct service.

Linkage with Early Years

In May, 1999, Regional Council endorsed a collaborative partnership between the Region's Community Services and Housing Department and its Health Services Department to develop a proposal to become an Early Years Demonstration Project site. York Region was selected in October, 1999. The Community Services and Housing Department has begun a process involving community partners in identifying and contacting organizations in Ontario currently incorporating elements of the Early Years model. The current integrated model within Social Services will serve as a base to link existing services in York Region with education, public health, child health, libraries and community recreation.

Benefits of Partnerships and Linkages

The program provides benefits to children and families, program staff, and the Social Services Department and its programs.

Benefits for Children and Families

Comprehensive Child Profiles — The team assessment model results in a more comprehensive profile of the child and better understanding of the interventions that are required.

Effective and Efficient Assessment and Planning — Team assessment and intervention planning is efficient and effective:

- children achieve their goals more quickly, and
- because skills are more consistently reinforced, the benefits tend to be maintained.

Continuity of Care — The opportunity for the same staff to provide service to the child and family from initiating service until school entry ensures a continuity of consistent care.

Seamless Services — Parents and children experience a seamless set of services. They do not need to seek related services from different organizations. Parents do not have to provide the same information more than once.

Consistent Information — Families receive consistent and knowledgeable information on child care issues and special needs supports from staff in both services.

Benefits for the Staff

Cross-Training — Cross-training provides staff with an expanded set of skills and a greater knowledge base.

Learning — Team assessments provide an opportunity for staff from different disciplines to learn from each other's perspectives and techniques.

Peer Support — In addition to supporting positive outcomes for children and families, peer support and consultation has a psychological benefit for staff. When professionals collaborate on the goals and intervention design for the family, less stress is placed on a single service provider.

Benefits for the Department

Recognition — York Region EIS has received the "Program Award for Significant Contribution in the field of Infant Development" from the Ontario Association for Infant Development for exemplary service, staff development and program

development. This form of recognition increases the prestige of the organization and contributes to positive morale.

Efficiency — The team assessment and planning process provides for more efficient role delineation and resource sharing, reducing duplication in services and/or materials.

Leveraging — Co-location creates leveraging opportunities. Since the services are in one location, multi-service events can more easily be co-ordinated.

Client Information and Technology

A common database was developed in-house and captures a range of demographic and service data for both Early Intervention Services and Preschool Speech and Language Program. In the future, the intent is for this database to interface with the databases for Healthy Babies Healthy Children and the Ontario Child Care System, Service Managers' Module.

Accountability

Measures are in place that allow:

- accountability to funders, and
- monitoring and evaluation.

Accountability to Funders

APERS (the MCSS reporting system) requires that the Consolidated Municipal Service Manager identify the costs associated with services provided under the *Day Nurseries Act* (*DNA*), Child Care Special Needs Resourcing (as well as the *DNA* funding approved for the Preschool Speech and Language Program) and under the *Child and Family Services Act*, Infant Development Program.

The EIS team approach involves both direct services (i.e., to clients) and indirect services (e.g., planning, team meetings). Direct services are carefully tracked in order to enable expenditures to be separately attributed to the programs and reported to the respective organizations. Some costs, e.g., for joint training activities, can only be identified by proportion.

Indirect services that are needed to foster and sustain a team approach, e.g., planning time and training, are tracked as well.

Monitoring and Evaluation

York Region EIS is the first program of its kind in Canada to receive accreditation through Accreditation Ontario utilizing the "Outcome Measures for Early

Childhood Intervention Services." This body typically accredits organizations providing services for individuals with developmental disabilities. In order to be accredited, the program must demonstrate the presence of 21 specified outcomes for the child and family, and the organizational process to support the attainment of each outcome.

A parent satisfaction survey is conducted regularly. This survey will be enhanced by soliciting parental input at multiple points during their contact with the EIS program. Service partners have opportunities to express concerns during joint meetings.

Political Support

Regional Council:

- approved co-location with the Preschool Speech and Language Program (PSLP), including cost-sharing arrangements, which are favourable to the PSLP and promoted the investment of funding in direct service to families,
- supported the report on the *Early Years Study*, recognizing the importance of investing in the early years, and
- endorsed York Region as an Early Years demonstration site.

Lessons Learned

Integration is not a finite process

As each element of the integration approach is incorporated, new opportunities present themselves.

Communicate with community partners

CMSMs need to communicate regularly with their community partners about the changes arising from the *Services Improvement Act*, in particular, the changing roles and responsibilities of CMSM's and MCSS for Child Care Service System Management.

Team Approach Adds Value

The value of teaming may not be seen primarily in terms of cost savings, although there are financial efficiencies, but rather in the quality of the services delivered, the outcomes for the families and children, and for the development of the staff. It may not be so much an issue of 'spending less for the same services' as it is of 'providing higher quality services for the same cost'.

Challenges and Successful Strategies

Creating Interdisciplinary Teams

Specialized professionals need to become familiar with each other's skills and to learn the value of each discipline's contribution to client well-being. While the result is better service for the client, creating such a team has 'add-on' administrative costs, takes time, and requires leadership. Although the costs lessen over time, teams require continuing support to remain cohesive and productive.

Maintaining Accountability to Funders

Accounting for time spent in joint activities of multidisciplinary teams is challenging. When team members, who are accountable to different organizations and whose positions are funded under different program streams, receive joint training (e.g., cognitive development in children with Down Syndrome), which funding stream should be charged? When a training session is provided to the community (e.g., to a Children's Aid Society) by an EIS staff person whose position is funded through both Infant Development and Child Care Special Needs Resourcing, against which funding envelope should the cost of training be levied – Child Care Special Needs Resourcing or Infant Development? If a proportional approach is taken, what should be the proportions assigned to each funding stream? This same issue arises in the data reporting for service delivery statistics. York Region's strategy has been to divide the costs according to the percentage of the population served.

Managing Two Groups of Home Visitors

Having both professional and lay home visitors involved with a family at the same time requires careful role delineation and planning for several reasons. Since lay home visitors do receive training and are paid, there is a risk that they come to see themselves as lower-paid professionals. A second consideration is that families may not want more than one home visitor in their homes. Home visits can create pressures on families, for example, they may want to clean up their homes or may have to rearrange their schedules.

"Ownership" of Clients

In traditional intervention approaches, staff retain a "treatment" role with the client for the duration of the intervention. In a team approach where different levels of intervention are delivered by different staff, staff may need to withdraw during the course of the intervention so that other staff whose skills may be more appropriate for the family's needs at that time can assume a greater role. Letting go may be difficult for some staff, particularly until sufficient trust develops among team members that the client's needs will be adequately met.

Future Plans

York Region staff have been involved in a focus group on the development of Intensive Early Intervention Services for Children with Autism. The integration approach developed for the EIS and Early Years will support service integration in the targeted Autism initiative, as it has done with the Child Care Enhancement program.

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ONTARIO WORKS AND CHILD CARE INTEGRATION

Synopsis

Approach – Parents participating in Ontario Works and who are eligible for child care are referred to Children's Services for an orientation to child care, support in making decisions about child care, and financial support for child care. OW parent participants may choose between licensed and informal care, as well as between centre-based and home-based care. They may also choose informal care provided through parks and recreation programs.

Information Sharing – Information sharing takes place between OW and Children's Services on an immediate-need-to-know basis. Once the initiative is fully implemented, workers in Children's Services will be able to enter child care information directly into Ontario Works technology and to generate cheques for OW participants who choose informal child care.

Challenge – A challenge faced in implementing this model is cross-training OW and Children's Services staff in the complexities of each program.

Benefits – OW parent participants receive support in decision-making regarding child care and receive co-ordinated services. Staff receiving cross-training become more highly skilled and knowledgeable.

Vision

Parents who are OW participants receive child care services and supports that enable them to make informed decisions, resulting in quality care for their children.

OW parent participants are assisted in their transition to employment, education and training.

Service Delivery

The Children's Services Unit is co-located with Ontario Works in the Ontario Works Office. All Ontario Works participants who are eligible for child care are referred by the Social Assistance Worker to a Children's Services Representative (CSR) in the Children's Services Unit except where the child care need is one-time only.

Under the service delivery model, Ontario Works parent participants receive:

- Orientation: Parents are provided with information on child care options, i.e., licensed or informal, and on what to look for when assessing the quality of child care.
- Decision-making Support: The CSR supports families in making choices among the types of care – licensed/unlicensed, centre-based/home child care – and ensures parents are aware of the longer term implications of their choices. CSRs encourage parents to choose programs that have a Purchase of Service Agreement with York Region.

Invoicing arrangements depend on the option selected by the family:

- If an OW family selects formal (licensed) care, the CSR contacts the provider and sets up a direct invoicing process.
- If an OW family selects informal (unlicensed) care through a recreation program operated by a local municipality, the CSR contacts the provider and sets up a direct invoicing process.
- Alternatively, if an OW family chooses informal home-based child care, the parent contacts the OW worker, who issues a cheque to the parent. Once the integrated model is fully implemented, the CSR will secure financial support for the parent choosing informal child care from OW child care funds, thereby ensuring that all child care-related activities are managed by one worker.

OW parents are not placed on a waiting list for child care – child care assistance is provided as required – nor are OW parents required to contribute to the financial cost of child care.

The CSR meets with the OW parents every six months to update information. This ensures that the family has regular contact with a consistent worker.

Linkages

CSRs attend OW Employment Resource Information Sessions to provide OW parent participants with information about child care options.

Ontario Works and Children's Services maintain strong links with:

- the Recreation Departments of local municipalities,
- Resource Centres and Boards of Education, through the Learning, Earning and Parenting (LEAP) initiative, and
- child care operators within the child care service system.

The units are also beginning to develop linkages with the York Region District School Board's Summer Institutes for child care placements and employment opportunities for OW participants.

Resourcing

OW participants who leave Ontario Works for employment or education, and are in receipt of child care fee assistance under the *Ontario Works Act*, are given immediate priority for child care fee assistance under the *Day Nurseries Act* (DNA). If there are no DNA fee subsidy dollars available, National Child Benefit (NCB) municipal reinvestment dollars are used to provide child care fee assistance on a temporary basis to ensure a smooth transition for the participant between OW and DNA fee assistance.

Client Information and Technology

Technology

The Ontario Child Care Management System (OCCMS) Service Manager's module has been implemented in York Region. This system identifies DNA, OW, LEAP and NCB participants.

The system allows CMSMs to track a range of client data including funding source, attendance, level of service, ages of children, type of care, etc. It is expected that as CMSMs gain familiarity with the system they will be able to generate more detailed custom reports on service usage.

Information Sharing between OW and Children's Services

The CSR collects basic information from the OW parent participants and enters it into the OCCMS. Reports on OW families are generated centrally in Children's Services. The OCCMS information is verified and entered into Ontario Works Technology (OWT) by OW staff, centrally. Future plans are for CSRs to enter the data directly into OWT.

The Region has recently developed protocols between the two programs for the sharing of immediate-need-to-know information about OW families. This includes changes in the parent's eligibility, absenteeism, termination, suspension, etc.

Benefits of Integrated Approach

This initiative is in the implementation stage. Some of the anticipated benefits are as follows:

Benefits for OW Parent Participants

OW parent participants are able to make informed choices as a result of receiving consistent and high quality information on child care issues.

Parents receive support in planning and selecting child care.

Parents receive timely child care services, enabling them to move forward with their return to work action plan.

Families have consistent contact with one worker, provide information only once, and receive seamless supports.

Benefits for Staff

OW and Children's Services staff are receiving cross-training. This will provide them with additional skills and knowledge.

Benefits to Community Services and Housing Department

A more integrated approach to the delivery of child care supports and services to OW parent participants is expected to result in greater efficiencies and more effective planning.

Accountability

In addition to other monitoring and evaluation activities, accountability will be achieved through cross-reporting, verification of data, caseload review and supervision using the OCCMS.

A regular parent satisfaction survey is conducted.

Service partners have opportunities to provide input during joint meetings.

Lessons Learned

Challenges

A challenge faced in implementing this model is cross-training staff groups in the complexities of the other program. Since both Children's Services and Ontario Works are complex, staff from both areas need time and support in order to become familiar with the options and terminology, for example,

- formal (licensed) care, which includes centre-based and licensed home child care,
- informal (unlicensed) care, which includes unlicensed home-based care as well as programs operated by Parks and Recreation that appear similar to licensed centre-based care,
- participation agreements, and
- purchase of service agreements.

Innovative Solutions

York Region has entered into Purchase of Service Agreements with local municipalities to provide services to OW families through their recreation programs. This type of child care can be more reliable (i.e., consistent) than informal home child care and affords a variety of options to families (sports, camp, special interest).

York Region is developing linkages with the York District School Board Summer Institutes for both child care placements and employment opportunities for OW participants.

Future Plans

As the integration model is not yet fully implemented, a number of objectives remain:

- expanding an existing centralized intake capacity to include screening for access, needs assessment and referral to all programs in the Community Services and Housing Department, and
- enabling CSRs to enter data directly into OWT and to generate cheques immediately for OW parent participants who choose informal child care for their children.

Impetus for Integration

Child care funded under the *Ontario Works Act* and under the *Day Nurseries Act* is now managed within one overall budget. CMSMs are required to meet specific requirements for tracking expenditures in each category separately. In managing within one overall budget, they are able achieve greater efficiency and to adopt a more flexible approach. This is best achieved through a single worker who is responsible for and knowledgeable about all child care options and funding criteria. An integrated approach provides OW families with effective support in their decision-making and a seamless transfer across funding streams as their circumstances change.

In addition, government initiatives have been developed to enhance child care options and employment supports, and to provide additional supports to children. These include LEAP, STEP, and NCB. As the Service System Manager for Child Care, York Region is working towards integrating these initiatives into the broader child care service system.

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